This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0051 Worksheet S Peri od: From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/28/2019 Time: 12:09 pm use only Manually submitted cost report

use only

Contractor

] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low.

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19]

(3) Settled with Audit (4) Reopened (5) Amended

number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLOOMINGTON HOSPITAL (15-0051) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

MI CHAEL CRAIG (Si gned)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER Title

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-43, 015	233, 853	0	0	1.00
2.00	Subprovi der - I PF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	-26, 402	-4		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	-69, 417	233, 849	0	0	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex indicated.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Heal th	Financial Systems	IU HEALTH	BLOOMI NG	TON HOSE	PLTAL			In Lieu (of Form	n CMS-2	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DA	ATA	Provid	der CC	N: 15-0051	Peri od: From 01/01 To 12/31	/2018 P /2018 D	orkshee art I ate/Tin /28/201	ne Pre	oared:
	1.00	2.	. 00		3. 00			4. 00	/20/20	19 12.	Ј9 рііі
	Hospital and Hospital Health Care Co										
1.00	Street: 601 WEST SECOND STREET	PO Box:									1.00
2. 00	Ci ty: BLOOMI NGTON	State: Component Na	ame	Zip Cod CCN Number	e: 474 CBS Numb	SA Provide	nty: MONROE er Date Certified		0, or 1	N)	2. 00
		1.00		2.00	2.0	20 4.00	F 00		XVIII	XIX	
	Hospital and Hospital-Based Componen	1.00		2.00	3.0	00 4.00	5. 00	6.00	7. 00	8. 00	
3.00	Hospi tal	I U HEALTH BLOOMI		150051	140	20 1	07/01/196	6 N	Р	Р	3. 00
		HOSPI TAL									
4. 00 5. 00	Subprovi der - IPF Subprovi der - IRF	IU HEALTH BLOOMI HOSPITAL	NGTON	15T051	140	20 5	10/01/200	2 N	Р	Р	4. 00 5. 00
6.00	Subprovider - (Other)					İ					6. 00
7.00	Swing Beds - SNF										7. 00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF										8. 00 9. 00
10. 00	Hospi tal -Based NF										10.00
11. 00	Hospi tal -Based OLTC										11. 00
12.00	Hospi tal -Based HHA										12. 00
13.00	Separately Certified ASC										13. 00
14. 00	Hospi tal -Based Hospi ce										14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15. 00 16. 00
17. 00	Hospital -Based (CMHC) I										17. 00
18.00	Renal Dialysis										18. 00
19. 00	Other										19. 00
							From 1.00		To: 2. 00		
20. 00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/2		20. 00
21. 00	Type of Control (see instructions)						2				21. 00
					-	1 00	2.0	0	2.00		
1.00 2.00 3.00 Inpatient PPS Information											
22. 00										22. 00	
22. 01	hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in column the portion of the cost reporting period.	compensated care mn 1, "Y" for yes riod occurring pr	payments s or "N" i rior to 0	for no f ctober 1	for I.	Y	Y				22. 01
22. 02	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N	er October 1. (se requires final u port settlement? " for no, for the	ee instrucuncompensa (see ins e portion	ctions) ated car tructior of the	re ns)	N	N				22. 02
	cost reporting period prior to Octobor "N" for no, for the portion of th October 1.	e cost reporting	peri od o	n or aft	ter						
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ds for delineating olumn 1, "Y" for g period prior to no for the portion of the continuous for the portion of the formal for the formal	ng statis yes or "I o October on of the ee instruc than 499	tical ar N" for r 1. Ente cost ctions) beds (a	reas no er	N	N		N		22. 03
23. 00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	dicaid days on li of admission, 2 i of identifying th method used in th	ines 24 au if census ne days in	nd/or 25 days, c n this c cost	or 3		3 N				23. 00
			In-State Medicaio paid day	d Medi 's elig unp da	ys	Out-of State Medicaid paid days	State Medi cai d el i gi bl e unpai d	Medicaid HMO days	Medi da	her cai d ays	
24. 00	If this provider is an IPPS hospital	enter the	1.00	2. 89	00 196	3. 00 15	4. 00	5. 00 14, 77		00	24. 00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	Ji		170	13	37	17, //		20	27.00

SPLL	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	.TA I	Provider CC	:N: 15-0051	Period: From 01, To 12,	/01/2018 /31/2018	Part I	eet S-2 ime Pre	
		In-State	In-State	Out-of	Out-of	Medi c	5/28/2	019 12: Other	
		Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO d	ays Me	di cai d days	
	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	1.00	2.00	3. 00		5. 0	251	6. 00	25
						/Rural S . 00	Date of 2.	f Geogr 00	1
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural.			ne	1			26 27
	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	"2" for r	ural. If ap column 2.	ppl i cabl e,					
	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	- number of	perrous SC	statuS IN					35
						nni ng: . 00	Endi 2.	ng: 00	
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date	es.	·						36
01	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for	ne MDH tran:	sitional pa	yment in		(37
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. If li	ne 37 is					38
	onto: Gazooquont dateo.					//N . 00		/N 00	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction	, (ii), or the mileage i)? Enter	(iii)? Ent requiremen n column 2	er in column nts in P "Y" for ye	me n	N N		V	39
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	"Y" for y			V	XVIII		
	December (DDC) Conital					1. 0		3. 00	1
00	<u>Prospective Payment System (PPS)-Capital</u> Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in a	accordanc	e N	Y	N	45
	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46
	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47
	Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p		1 3		,	N			5 <i>6</i>
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N th of this of (", completo , if applic	'for no in cost report Worksheet cable.	n column 1. ing period? : E-4. If co	f column Enter " umn 2 is	Y"			
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	complete W	kst. D-5.		s as	N			58 59
				NAHE 413.8 Y/N		sheet A ne #	Pass-T Qualifi Criteri	cation	
00	Are you claiming purcing and allied health adviction	(NAUE) and	te for	1. 00 Y	2	. 00	3.	00	11
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (If line 60 is yes, complete columns 2 and 3 for each			Y		23. 00			60

	1.00							
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which	0.00	62.00						
your hospital received HRSA PCRE funding (see instructions)								
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0.00	62. 01						
during in this cost reporting period of HRSA THC program. (see instructions)								
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter	N	63. 00						
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)								
	Ratio (col. 1/							
FTES FTES in	(col. 1 + col.							
Nonprovi der Hospi tal	2))							
Si te	, ,							
1.00 2.00	3.00							
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost r	eporting							
period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00	0. 000000	64.00						
in the base year period, the number of unweighted non-primary care								
resident FTEs attributable to rotations occurring in all nonprovider								
settings. Enter in column 2 the number of unweighted non-primary care								
resident FTEs that trained in your hospital. Enter in column 3 the ratio								
of (column 1 divided by (column 1 + column 2)). (see instructions)								

0.00

0.00 61.20

unweighted count. Enter in column 4, the direct GME

program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,

61.20 Of the FTEs in line 61.05, specify each expanded

the direct GME FTE unweighted count.

FTE unweighted count.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 12:09 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

100:00 IT this raciffty qualiffies as a only has it created the arr			100.00		
for outpatient services? (see instructions)					
107.00 If this facility qualifies as a CAH, is it eligible for cos	t reimbursemen	t for I&R			107. 00
training programs? Enter "Y" for yes or "N" for no in column	n 1. (see inst	ructions) If			
yes, the GME elimination is not made on Wkst. B, Pt. I, col.					
reimbursed. If yes complete Wkst. D-2, Pt. II.	20 and the p	. og. a o ooot			
108.00 Is this a rural hospital qualifying for an exception to the	CDNA foo scho	dul a2 Saa 42	N		108, 00
	IN.		100.00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are					109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
i.e. yee e. ii te. iie te. eas the apy.					
				1 00	4
				1. 00	
110 00 Did this hospital participate in the Rural Community Hospita	al Demonstrati	on project (§41	OA	l N	110 00

Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as

MCRI F32 - 15. 5. 166. 1

appl i cabl e.

are claimed, enter in column 2 the home office chain number. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number

Name: INDIANA UNIVERSITY HEALTH INC | Contractor's Name: WPS 141. 00 Name: I NDI ANA UNI VERSI TY HEALTH I NC Contractor's Number: 08101 141 00 142.00 Street: 340 W. 10TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS 46202-3082 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 11/15/2018 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2018 03/31/2018 170. 00 period respectively (mm/dd/yyyy) 1.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 1, 228 171. 00 section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	04/03/2019	Υ	04/03/2019	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					l

Health Financial Systems IU HEALTH BLOOMI HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		- CCN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	u of Form CM Worksheet S Part II Date/Time P	-2						
			10 12/31/2016	5/28/2019 1							
	Descr	i pti on	Y/N	Y/N							
		0	1. 00	3. 00							
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00						
	Y/N	Date	Y/N	Date							
	1.00	2.00	3. 00	4. 00							
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00						
				1. 00							
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)									
Capital Related Cost											
22.00 Have assets been relifed for Medicare purposes? If yes, see					22. 00 23. 00						
	reporting period? If yes, see instructions. ON Were new Leases and/or amendments to existing Leases entered into during this cost reporting period?										
24.00 Were new leases and/or amendments to existing leases entered lf yes, see instructions	sa riito auring	till S COSt FE	sporting period?		24. 00						
25.00 Have there been new capitalized leases entered into during	the cost repo	rting period?	lf yes, see		25. 00						
instructions.		5 1	J ,								
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during thin instructions.	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see										
27.00 Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	ges, submit		27. 00						
Interest Expense					28. 00						
28.00 Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.											
li s i											
treated as a funded depreciation account? If yes, see instr			,		29. 00						
30.00 Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes	s, see		30. 00						
instructions.					21 00						
31.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance or new	debt? IT yes	s, see		31.00						
Purchased Services											
32.00 Have changes or new agreements occurred in patient care ser	rvices furnish	ed through co	ntractual		32. 00						
arrangements with suppliers of services? If yes, see instru											
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertainii	ng to competi	tive bidding? If		33. 00						
no, see instructions. Provider-Based Physicians											
34.00 Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physicians?		34.00						
If yes, see instructions.	rangomorre in th	. p. 01. do. 20	issu pilysi si alisi		0 11 00						
35.00 If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 00						
physicians during the cost reporting period? If yes, see in	nstructions.	_	V/ /N	Б							
			Y/N 1. 00	2. 00							
Home Office Costs			1.00	2.00							
36.00 Were home office costs claimed on the cost report?					36.00						
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	>		37. 00						
If yes, see instructions.	- ·										
38.00 If line 36 is yes, was the fiscal year end of the home off			-		38. 00						
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to other					39. 00						
see instructions.	ar Charn Compo	ients: II yes	0,		39.00						
40.00 If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00						
	1.	. 00	2.	00							
Cost Report Preparer Contact Information	DUONDA		UTTED		44 00						
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41. 00						
respectively.											
42.00 Enter the employer/company name of the cost report	INDIANA UNIVER		42. 00								
preparer.											
· ·	317-962-1093		RUTTER@I UHEALT	H. ORG	43. 00						
report preparer in columns 1 and 2, respectively.	I										

In Lieu of Form CMS-2552-10			
t S-2			
e Prepared:			
9 12:09 pm			
41.00			
42.00			
43.00			
1			

 Heal th Financial
 Systems
 I U HEALTH

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0051

					T	o 12/31/2018		
							5/28/2019 12: I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	NO.	or beas	Avai I abl e	CAIT HOURS	II LI C V	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		206			0.00	1. 00
00	8 exclude Swing Bed, Observation Bed and	00.00		200	, 0, 1, 0	0.00	ŭ	
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2, 00
3.00	HMO IPF Subprovider							3. 00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			206	75, 190	0.00	Ö	
7.00	beds) (see instructions)			200	, 0, 1, 0	0.00	ŭ	/
8.00	INTENSIVE CARE UNIT	31. 00		16	5, 840	0.00	0	8.00
9.00	CORONARY CARE UNIT	32. 00	1	14	· ·		0	9, 00
10.00	BURN INTENSIVE CARE UNIT				-,			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		18	6, 570	0.00	0	1
13. 00	NURSERY	43. 00			-,		Ō	13. 00
14. 00	Total (see instructions)			254	92, 710	0.00	Ō	
15. 00	CAH visits				,		0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF	41. 00		16	5, 840)	0	17. 00
18.00	SUBPROVI DER	42. 00		0	C)	0	18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22.00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24.00	HOSPI CE	116. 00		0	C)		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			270				27. 00
28.00	Observation Bed Days						0	28. 00
29.00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			12	4, 380)		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

Provider CCN: 15-0051

						5/28/2019 12:	09 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	18, 260	375	43, 909			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	6, 171	13, 398				2. 00
3.00	HMO IPF Subprovider	o	O				3. 00
4.00	HMO IRF Subprovider	239	251				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6.00
7.00	Total Adults and Peds. (exclude observation	18, 260	375	43, 909			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	2, 121	190	4, 035			8. 00
9.00	CORONARY CARE UNIT	1, 686	0	3, 424			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	ol	10	3, 748			12.00
13. 00	NURSERY		1, 641	3, 495			13.00
14.00	Total (see instructions)	22, 067	2, 216	58, 611		1, 696. 47	14.00
15. 00	CAH visits	0	Ö	0		,	15. 00
16, 00	SUBPROVIDER - IPF						16, 00
17. 00	SUBPROVIDER - IRF	1, 850	13	2, 834	0.00	0.00	17. 00
18. 00	SUBPROVI DER	.,	0	0	0.00	l e	1
19. 00	SKILLED NURSING FACILITY		1				19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00		0	0	0	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		1		0.00	l	ł
24. 00	HOSPI CE	0	0	0		•	
24. 10	HOSPICE (non-distinct part)		1	20			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00			1	_	0.00		
28. 00	Observation Bed Days		98	4, 514		.,	28. 00
29. 00		8, 081		.,			29. 00
30. 00	The state of the s	2,001		0			30.00
31. 00	. ,			0			31.00
32. 00	Labor & delivery days (see instructions)	0	26	852			32.00
32. 01	Total ancillary labor & delivery room		20	0			32. 01
02.01	outpatient days (see instructions)			Ü			52.51
33. 00		o					33.00
	LTCH site neutral days and discharges	o					33. 01
	, J	, -1	'		'	'	

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0051

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 12:09 pm Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 4, 643 113 14, 198 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 1, 265 2 00 2.672 HMO IPF Subprovider 3.00 3.00 HMO IRF Subprovider 4.00 22 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 NEONATAL INTENSIVE CARE UNIT 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 4,643 113 14, 198 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 250 17.00 0.00 165 17.00 18.00 SUBPROVI DER 0.00 0 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0.00 23.00 HOSPI CE 0.00 24 00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0.00 26, 25 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0051 Period:

					Т	o 12/31/2018	Date/Time Prep 5/28/2019 12:0	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	57 piii
		1.00	2.00	A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
4 00	SALARI ES	202 22	10/ 504 017	(00.040	105 074 0/0	2 502 /// 00	20.00	1 00
1. 00	Total salaries (see instructions)	200. 00	106, 504, 817	-632, 849	105, 871, 968	3, 528, 666. 00	30. 00	1. 00
2.00	Non-physician anesthetist Part A		C	0	0	0.00	0.00	2. 00
3.00	Non-physician anesthetist Part		C	0	О	0.00	0. 00	3. 00
4.00	B Physician-Part A -		367, 307	0	367, 307	6, 604. 00	55. 62	4. 00
4. 01	Administrative Physicians - Part A - Teaching		C	0	0	0. 00	0. 00	4. 01
5.00	Physician and Non Physician-Part B		1, 493, 635	0	1, 493, 635	14, 927. 00	100. 06	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		C	0	0	0.00	0.00	6. 00
7.00	Interns & residents (in an	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		C	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related		C	0	0	0.00	0.00	8. 00
9. 00	organization personnel SNF	44. 00	C	0	0	0. 00		
10. 00	Excluded area salaries (see instructions)		11, 356, 506	1, 782, 135	13, 138, 641	496, 983. 00	26. 44	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		5, 531, 755	0	5, 531, 755	80, 093. 00	69. 07	11. 00
12. 00	Care		0, 001, 700			0.00		12. 00
12.00	Contract labor: Top level management and other management and administrative		C			0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		1, 417, 155	0	1, 417, 155	9, 150. 00	154. 88	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		C	0	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		27, 667, 457	0	27, 667, 457	799, 857. 00	34. 59	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00		14. 02 15. 00
	- Administrative							
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		30, 115, 265	0	30, 115, 265			17. 00
18. 00	instructions) Wage-related costs (other)		C	0	0			18. 00
19. 00	(see instructions) Excluded areas		4, 640, 576	0	4, 640, 576			19. 00
20. 00	Non-physician anesthetist Part		4, 640, 576 C	0	4, 640, 576			20. 00
21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22. 00	B Physician Part A -		95, 930	0	95, 930			22. 00
22. 01	Administrative Physician Part A - Teaching		C	0	o			22. 01
23. 00	Physician Part B		301, 254	0	301, 254			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		7, 997, 684	0	7, 997, 684			25. 50
25. 51	(core) Related organization		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0					25. 52
20. 02	- Administrative - wage-related (core)		C					20. 02
25. 53	Home office & Contract Physicians Part A - Teaching -		C	0	0			25. 53
	wage-related (core)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	1, 234, 139	-59, 114	1, 175, 025	8, 712. 00	134, 87	26. 00
27. 00	Administrative & General	5. 00	6, 769, 590	•				27. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2018 Part II

To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm

							5/28/2019 12: (09 pm_
		Wkst. A Line		Recl assi fi cati		Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		2, 982, 744	0	2, 982, 744	19, 115. 00	156. 04	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	2, 125, 486	-6, 550	2, 118, 936	80, 705. 00	26. 26	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00		31.00
32.00	Housekeepi ng	9. 00	1, 808, 827	-11, 747	1, 797, 080	130, 597. 00	13. 76	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	2, 141, 686	-1, 063, 487	1, 078, 199	60, 461. 00	17. 83	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	1, 053, 647	1, 053, 647	69, 610. 00	15. 14	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	6, 877, 080	-762, 887	6, 114, 193	172, 180. 00	35. 51	38.00
39. 00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	5, 127, 001	-558, 064	4, 568, 937	117, 097. 00	39. 02	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	505, 952	-4, 941	501, 011	27, 005. 00	18. 55	43.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 12: 09 pm | Poid Hours | Average Hours | Part III | Provider CCN: 15-0051

		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		107, 993, 926	-632, 849	107, 361, 077	3, 532, 854. 00	30. 39	1.00
	instructions)							
2.00	Excluded area salaries (see		11, 356, 506	1, 782, 135	13, 138, 641	496, 983. 00	26. 44	2.00
	instructions)							
3.00	Subtotal salaries (line 1		96, 637, 420	-2, 414, 984	94, 222, 436	3, 035, 871. 00	31. 04	3.00
	minus line 2)							
4.00	Subtotal other wages & related		34, 616, 367	0	34, 616, 367	889, 100. 00	38. 93	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		38, 208, 879	0	38, 208, 879	0.00	40. 55	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		169, 462, 666	-2, 414, 984	167, 047, 682	3, 924, 971. 00	42. 56	6.00
7.00	Total overhead cost (see		29, 572, 505	-1, 880, 297	27, 692, 208	815, 375. 00	33. 96	7. 00
	instructions)							

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0051	Peri od: Worksheet S-3
		From 01/01/2018 Part IV
		T- 10/01/0010 D-+-/T: D

	To 12/31/2018	Date/Time Prep 5/28/2019 12:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1. 00	401K Employer Contributions	3, 865, 650	1. 00
2. 00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3. 00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	
4.00	Qualified Defined Benefit Plan Cost (see instructions)	7, 416, 689	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5. 00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	14, 401, 099	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	482, 941	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	53, 185	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
	Disability Insurance (If employee is owner or beneficiary)	814, 650	13. 00
		0	14. 00
15. 00	'Workers' Compensation Insurance	574, 925	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		
	FICA-Employers Portion Only	7, 508, 038	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	17, 188	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	18, 659	
24.00	Total Wage Related cost (Sum of lines 1 -23)	35, 153, 024	24. 00
	Part B - Other than Core Related Cost		l
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0051	Peri od:	Worksheet S-3
		From 01/01/2018	

		0 12/31/2018	Date/IIMe Prep 5/28/2019 12:0	
	Cost Center Description	Contract Labor	Benefit Cost	9 p
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17.00
18. 00	Other	o	0	18. 00

Heal th	Financial Systems IU HEALTH BLOOMINGTO	ON HOSPITAL	In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0051	Peri od:	Worksheet S-10	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:
			10 12/31/2010	5/28/2019 12:0	
				1. 00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by line 202 colu	mn 8)	0. 179478	1. 00
2. 00	Net revenue from Medicaid			34, 952, 504	2. 00
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ Υ	3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal payments from Medi	cai d?	Υ	4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid		0	5. 00
6. 00	Medi cai d charges			268, 516, 222	6. 00
7.00	Medicaid cost (line 1 times line 6)	(1) 7	0 15 16	48, 192, 754	
8. 00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(line / minus sum of l	nes 2 and 5; IT	13, 240, 250	8. 00
	Children's Health Insurance Program (CHIP) (see instructions for	or each line)			
9.00	Net revenue from stand-alone CHIP			0	9. 00
10.00	Stand-alone CHIP charges				10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				11. 00
12. 00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(line 11 minus line 9;	if < zero then	0	12. 00
	Other state or local government indigent care program (see ins	tructions for each line	<i>i</i>)		
13. 00	Net revenue from state or local indigent care program (Not inc			0	13. 00
14. 00	Charges for patients covered under state or local indigent car			0	14. 00
	10)				
15. 00	State or local indigent care program cost (line 1 times line 1		45 ' ''		15.00
16. 00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero)	digent care program (i	ne 15 minus iine	U	16. 00
	Grants, donations and total unreimbursed cost for Medicaid, CH	P and state/local indi	gent care program	ıs (see	
17. 00	instructions for each line) Private grants, donations, or endowment income restricted to f	unding charity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of	9		0	18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca		ms (sum of lines	13, 240, 250	
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1	
		patients		+ col . 2)	
		1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)				
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	cility 26, 283,	995 511, 406	26, 795, 401	20.00
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see 4,717,	399 511, 406	5, 228, 805	21. 00
00.00	instructions)		204	440.045	00.00
22. 00	Payments received from patients for amounts previously written charity care	off as 96,	921 16, 444	113, 365	22.00
23. 00	Cost of charity care (line 21 minus line 22)	4, 620,	478 494, 962	5, 115, 440	23. 00
				4 00	
24 00	Does the amount on line 20 column 2, include charges for patie	at days bayand a Langt	of stay limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care		TOT Stay TIME	IN	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond t stay limit		am's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see in	structions)		20, 863, 509	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital comple	•		961, 814	1
27. 01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1, 479, 713	27. 01
28. 00	Non-Medicare bad debt expense (see instructions)			19, 383, 796	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see instructions	5)	3, 996, 864	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			9, 112, 304	30.00
21 00	Total unreimbursed and uncompensated care cost (line 19 plus l	ino 20)		22, 352, 554	

		U HEALTH BLOOMING				u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (UF EXPENSES	Provi der CO		Period: From 01/01/2018	Worksheet A	
				-	Γο 12/31/2018		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/28/2019 12: Reclassi fi ed	U9 pili
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		0	(10, 455, 269	10, 455, 269	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(6, 311, 665	6, 311, 665	
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 234, 139	954, 346	2, 188, 48!	0 5 18, 559, 927	0 20, 748, 412	
5. 00	00500 ADMINISTRATIVE & GENERAL	6, 769, 590	79, 176, 296			82, 877, 404	
7.00	00700 OPERATION OF PLANT	2, 125, 486	17, 189, 118			12, 353, 210	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	191, 482			181, 017	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 808, 827 2, 141, 686	1, 772, 467 2, 089, 332			2, 971, 199 1, 730, 886	
11. 00	01100 CAFETERI A	2, 141, 000	2,007,332	4, 231, 010	1, 930, 163	1, 730, 363	
13.00	01300 NURSING ADMINISTRATION	6, 877, 080	2, 835, 767	9, 712, 84		7, 331, 865	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	282, 521	282, 52			
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5, 127, 001	21, 241, 511 181, 459			5, 593, 901 179, 640	1
18. 00	01850 SOCIAL SERVICES		101, 437	101, 43		177,040	1
18. 01	01851 CENTRAL STERILIZATION	505, 952	587, 887	1, 093, 839	-508, 901	584, 938	1
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	119, 241	41, 901	161, 142	165, 767	326, 909	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	21, 698, 349	16, 566, 104	38, 264, 453	-7, 078, 544	31, 185, 909	30.00
31. 00	03100 NTENSI VE CARE UNIT	2, 851, 251	1, 797, 479				
32.00	03200 CORONARY CARE UNIT	2, 326, 537	912, 748			2, 565, 581	•
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 887, 395	1, 525, 843				
41. 00 42. 00	O4100 SUBPROVI DER	939, 625	395, 295		-251, 286 0	1, 083, 634	41. 00 42. 00
42.00	04300 NURSERY	0	0		728, 762	728, 762	1
10.00	ANCILLARY SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,	720, 702]
50.00	05000 OPERATING ROOM	5, 319, 869	26, 772, 594	32, 092, 463	-23, 298, 657	8, 793, 806	1
50. 01 51. 00	O5001 CV SURGERY O5100 RECOVERY ROOM	2, 994, 711	957, 461	3, 952, 172	0	2 240 050	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 851, 340	1, 744, 851	4, 596, 19°		3, 240, 859 3, 440, 299	1
53. 00	05300 ANESTHESI OLOGY	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 172, 842	2, 895, 707			3, 537, 773	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	2, 429, 072	2, 934, 913	5, 363, 98!	-1, 618, 762	3, 745, 223 0	1
57. 00	05700 CT SCAN	681, 234	861, 090	1, 542, 324	-744, 935	797, 389	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	390, 474	775, 965			426, 062	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 268, 311	9, 021, 480			1, 398, 409	1
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	11, 709, 116	11, 709, 110		11, 614, 257 0	1
65. 00	06500 RESPIRATORY THERAPY	2, 259, 504	1, 222, 302	1	ار ا	2, 448, 329	
66.00		6, 642, 393	2, 474, 955				
	06700 OCCUPATI ONAL THERAPY	0	0	(0		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	863, 386	0 785, 284	1, 648, 670	0 -689, 375	0 959, 295	
70. 00	07000 ELECTROENCEPHALOGRAPHY	180, 696	1, 253, 267	1, 433, 963		1, 294, 656	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	, , , , ,	9, 499, 925	9, 499, 925	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(16, 920, 065	16, 920, 065	1
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07302 OP PHARMACY	0	0 7, 781	7, 78	20, 763, 918 1 -7, 781	20, 763, 918 0	1
74. 00	07400 RENAL DI ALYSI S	40	1, 290, 239			1, 254, 065	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0	0	75. 01
76. 97	O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	616, 596	202, 374	818, 970	-138, 393	680, 577	76. 97
90. 00	09000 CLINIC	1, 283, 815	382, 908	1, 666, 723	-382, 303	1, 284, 420	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	1, 522, 491	2, 294, 504			2, 908, 227	
90. 02	09002 WOUND CARE CENTER	590, 101	624, 103			889, 143	1
90. 03 90. 05	O9003 PAIN CLINIC O9005 OP PSYCH CLINIC	203, 854 1, 772, 696	179, 730 615, 162			259, 187 2, 233, 750	
91.00	09100 EMERGENCY	4, 751, 593	5, 411, 088				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		., . ,	, , , , ,		, ,	92. 00
	OTHER REIMBURSABLE COST CENTERS				-1 -		
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0 5, 084, 961	3 350 004	0 224 041	0	0 4 207 17E	
	10000 I &R SERVICES-NOT APPRVD PRGM	5,064,961	3, 250, 004 0	8, 334, 96!	-2, 127, 790		100.00
	10100 HOME HEALTH AGENCY	Ö			o		101. 00
	SPECIAL PURPOSE COST CENTERS			_			
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF		1, 159, 385	1, 159, 38!	-1, 159, 385		113. 00 114. 00
	11400 UTLIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0				115. 00
	11600 HOSPI CE	o o	0		o o		116. 00
		·					

Health Financial Systems	J HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
				From 01/01/2018 To 12/31/2018	Date/Time Prep	ared.
				10 12/31/2010	5/28/2019 12:0	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	•
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00	0.00		col . 4)	
440.00	1.00	2.00	3.00	4. 00	5. 00	110.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	101, 292, 138	226, 567, 819	327, 859, 95	7 -1, 028, 444	326, 831, 513	118.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57, 442	88, 460	145, 90	2 -28, 561	117, 341	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 532, 403	1, 208, 659	2, 741, 06	•	2, 084, 502	
190. 01 19001 PROMPTCARE 190. 02 19002 RENTAL PROPERTIES	1, 332, 403	28, 996	2, 741, 06	•	16, 018	
190. 03 19003 OLCOTT	381, 204	144, 663		•	436, 634	
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	144, 003	323, 00	07, 233		190. 04
190. 05 19005 FOUNDATION	o	78, 437	78, 43	7 -77, 734		190. 05
190. 06 19006 MARKETI NG	o	0	707 10	0 0		190. 06
190. 07 19007 HME STORE	o	-1, 531	-1, 53	1 2, 411		190. 07
190. 08 19008 UNUSED SPACE	О	0		0 0	0	190. 08
190. 09 19009 CLINICAL TRIALS	142, 245	50, 960	193, 20	5 -29, 360	163, 845	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	3, 099, 385	2, 433, 264	5, 532, 64	9 -800, 488	4, 732, 161	190. 11
191. 00 19100 RESEARCH	0	0		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00
193.00 19300 NONPALD WORKERS	0	0		0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0		0 825, 687	825, 687	
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0		0 1, 895, 260	1, 895, 260	
194. 02 07952 IU HEALTH MORGAN HOSPITAL	0	0		0		194. 02
194. 03 07953 I U HEALTH SIP	0	0		0		194. 03
194. 04 07954 HOME CARE	0	0		0		194. 04
194. 05 07955 HOSPI CE	10/ 504 617	0	227 404 54	0		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	106, 504, 817	230, 599, 727	337, 104, 54	4 0	337, 104, 544	200.00

	Financial Systems	IU HEALTH BLOOMI				u of Form CMS-2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CC	:N: 15-0051	Peri od: From 01/01/2018	Worksheet A
					To 12/31/2018	Date/Time Prepared: 5/28/2019 12:09 pm
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
		6.00	7. 00			
4 00	GENERAL SERVI CE COST CENTERS	4 (40 (07	5 005 F70			1.00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-4, 649, 697 5, 438, 811				1. 00
3.00	00300 OTHER CAP REL COSTS	0, 430, 611				3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	10, 922, 209	1			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-34, 894, 441				5. 00
7.00	00700 OPERATION OF PLANT	-602, 148				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-53, 915				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	-38, 000 -232, 518				9. 00 10. 00
11. 00	01100 CAFETERI A	-1, 132, 008				11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-1, 059, 430				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 238, 131			14. 00
15. 00	01500 PHARMACY	-77, 654				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	179, 640			16. 00
18. 00 18. 01	01850 SOCI AL SERVI CES 01851 CENTRAL STERI LI ZATI ON	0	0 584, 938			18.00
	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	-66, 570				18. 01 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	-00, 370	200, 337			23.00
30. 00	03000 ADULTS & PEDIATRICS	-1, 217, 712	29, 968, 197			30.00
31.00	03100 INTENSIVE CARE UNIT	0	3, 531, 587			31. 00
32.00	03200 CORONARY CARE UNIT	-24, 000				32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-478, 653				35. 00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	-209, 663 0				41. 00 42. 00
43. 00	04300 NURSERY	0				43. 00
.0.00	ANCILLARY SERVICE COST CENTERS		7207702			10.00
50.00	05000 OPERATING ROOM	-22, 370	8, 771, 436			50. 00
50. 01	05001 CV SURGERY	0	0			50. 01
51.00	05100 RECOVERY ROOM	0	3, 240, 859			51. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	3, 440, 299			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-2, 504	1			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-318, 184				55. 00
56. 00	05600 RADI 0I SOTOPE	0	0			56. 00
57.00	05700 CT SCAN	0	797, 389			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	426, 062			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	1, 398, 409			59.00
60. 00 64. 00	06400 I NTRAVENOUS THERAPY	0	11, 614, 257 0			60. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 229				65. 00
66. 00	06600 PHYSI CAL THERAPY	-217, 050				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	l .			68. 00
	06900 ELECTROCARDI OLOGY	-90, 520				69.00
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-26, 267	1, 268, 389 9, 499, 925			70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	16, 920, 065			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	20, 763, 918			73. 00
73. 01	07302 OP PHARMACY	0	0			73. 01
	07400 RENAL DI ALYSI S	0	1, 254, 065			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			75. 00
75. 01 76. 07	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	0 -204	680, 373			75. 01 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	-204	000, 373			70. 77
90. 00	09000 CLI NI C	-37, 007	1, 247, 413			90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	2, 908, 227			90. 01
90. 02	09002 WOUND CARE CENTER	-374, 663				90. 02
90. 03	09003 PAIN CLINIC	0	259, 187			90. 03
90. 05 91. 00	09005 OP PSYCH CLINIC 09100 EMERGENCY	-675, 344 -1, 624, 685				90. 05 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-1,024,003	0, 310, 036			92. 00
, 2. 00	OTHER REIMBURSABLE COST CENTERS					72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0			94. 00
	09500 AMBULANCE SERVICES	-259, 077	5, 948, 098			95. 00
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	0			100. 00
101.00	10100 HOME HEALTH AGENCY	0	0			101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE	0	O			113. 00
	11400 UTILIZATION REVIEW-SNF					114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	o o			115. 00
115.00		i				1444 00
	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117	0 7) -32, 022, 035	0 294, 809, 478			116. 00 118. 00

Health Financial Systems IU HEALTH BLORGE RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Health Financial Systems	U HEALTH BLOOM!!	NGTON HOSPITAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CCN: 15-005	Peri od: From 01/01/2018 To 12/31/2018	Worksheet A Date/Time Prepared: 5/28/2019 12:09 pm
Cost Center Description	Adjustments	Net Expenses		072072017 12.07 piii
555t 5511tG. 5555t pt. 611		For Allocation		
	6.00	7.00		
NONREI MBURSABLE COST CENTERS		•		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	117, 341		190. 00
190. 01 19001 PROMPTCARE	-43, 855	2, 040, 647		190. 01
190. 02 19002 RENTAL PROPERTIES	0	16, 018		190. 02
190. 03 19003 OLCOTT	0	436, 634		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	О		190. 04
190. 05 19005 FOUNDATI ON	0	703		190. 05
190. 06 19006 MARKETI NG	0	О		190. 06
190.07 19007 HME STORE	0	880		190. 07
190. 08 19008 UNUSED SPACE	0	0		190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	163, 845		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	О		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	-1, 000	4, 731, 161		190. 11
191. 00 19100 RESEARCH	0	О		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	О		192. 00
193. 00 19300 NONPALD WORKERS	0	О		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	825, 687		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	1, 895, 260		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	О		194. 02
194.03 07953 IU HEALTH SIP	0	О		194. 03
194.04 07954 HOME CARE	0	0		194. 04
194. 05 07955 HOSPI CE	0	О		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-32, 066, 890	305, 037, 654		200. 00

IU HEALTH BLOOMINGTON HOSPITAL

Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm

					5/28/2019 12:	09 pm
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - BENEFITS	0.00	1. 00	0.00		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18, 752, 207		1.00
2.00	FOUNDATI ON	190. 05	0	152		2. 00
3.00		0.00	O	0		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	Ö	Ö		15. 00
16. 00		0.00	Ö	Ö		16. 00
17. 00		0.00	O	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0. 00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	Ö	Ö		29. 00
30.00		0.00	o	Ö		30.00
31.00		0.00	0	0		31. 00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34. 00
35. 00		0.00	0	0		35. 00
36. 00		0.00	0	0		36.00
37. 00 38. 00		0. 00 0. 00	0	0		37. 00 38. 00
39. 00		0.00	0	0		39. 00
07.00			 	18, 752, 359		07.00
	B - CAPITAL RELATED		-1	, , , , , , , , , , , , , , , , , , , ,		1
	CAP REL COSTS-BLDG & FIXT	1.00	0	8, 159, 871		1. 00
	CAP REL COSTS-MVBLE EQUIP	2. 00	0	5, 909, 700		2. 00
	RENTAL PROPERTIES	190. 02	0	20, 682		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	o	ő		9. 00
10. 00		0.00	Ö	Ö		10.00
11. 00		0.00	Ö	Ö		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		21.00
21.00		0.00	0	0		21.00
23. 00		0.00	0	0		23. 00
24. 00		0.00	o	Ö		24. 00
25. 00		0.00	Ö	Ö		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	О	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
		0.00				
30. 00		0.00	0	0		30. 00
30. 00 31. 00 32. 00						

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm

		Increases			5/28/2019 12	:09 pm
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5. 00		
33. 00		0.00	0	0		33. 00
34.00		0.00	0	0		34. 00
35. 00		0.00	0	0		35. 00
36. 00		0.00	0	0		36. 00
37. 00		0.00	0	0		37. 00
38. 00 39. 00		0. 00 0. 00	0	0		38. 00 39. 00
40. 00		0.00	0	0		40.00
41. 00		0.00	ő	Ö		41. 00
42.00		0.00	0	0		42.00
43.00		0.00	o	0		43.00
	0		0	14, 090, 253		
	C - BILLABLE MEDICAL SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00		1, 218		1.00
2. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		9, 499, 925		2. 00
3.00	FATTENTS	0.00	o	0		3. 00
4. 00		0.00	o	Ö		4. 00
5.00		0.00	O	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	o	0		13. 00
14. 00		0.00	Ö	Ö		14. 00
15.00		0.00	O	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	Ö		24. 00
25. 00		0.00	O	Ö		25. 00
26.00		0.00	О	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	•	0		29. 00
	D - BILLABLE DRUGS		0	9, 501, 143		
1.00	ADMINISTRATIVE & GENERAL	5. 00		861		1.00
2.00	HME STORE	190. 07		4, 608		2.00
3.00	DRUGS CHARGED TO PATIENTS	73. 00		20, 763, 918		3. 00
4.00		0.00	О	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	Ö		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
20.00		0.00	0	0		21.00
22. 00		0.00	0	0		22. 00
23. 00		0.00	Ö	Ö		23. 00
24. 00		0.00	0_	0		24. 00
	0		0	20, 769, 387]
	E - IMPLANTS SUPPLIES					
1.00	IMPL. DEV. CHARGED TO	72. 00		16, 920, 065		1. 00
2.00	PATI ENTS	0.00	0	О		2. 00
2.00	1	0.00	٠	٥Į		2.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 12:09 pm Provider CCN: 15-0051

					5/28/2019 12:	:09 pm
		Increases		211		
	Cost Center	Li ne #	Salary	Other 5		
2.00	2. 00	3.00	4.00	5. 00		2 00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	o		6. 00
7. 00		0.00	o	o		7. 00
8. 00		0.00	o	o		8.00
9. 00		0.00	o	0		9. 00
10. 00		0.00	o	o		10.00
11. 00		0.00	ő	o		11.00
12. 00		0.00	o	o		12. 00
13. 00		0.00	o	o		13. 00
14. 00		0.00	o	o		14. 00
15. 00		0.00	Ö	o		15. 00
16. 00		0.00	Ö	o		16. 00
				16, 920, 065		
	F - LEASE EXPENSE			<u> </u>		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 136, 013		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	363, 919		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14. 00
15. 00		0.00		0		15. 00
	C NON DILLARIE DDUCC		0	1, 499, 932		-
1.00	G - NON-BILLABLE DRUGS ADMINISTRATIVE & GENERAL	5.00	0	2, 191		1.00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	13, 714		2. 00
3.00	PHARMACY	15. 00	o	723, 084		3. 00
4. 00	ITTANWACT	0.00	o	723, 004		4. 00
5. 00		0.00	o	o		5. 00
6. 00		0.00	o	o		6. 00
7. 00		0.00	Ö	o		7. 00
8. 00		0.00	Ö	o		8. 00
9. 00		0.00	O	0		9. 00
10.00		0.00	О	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	О		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	<u>0</u> 738, 989		28. 00
	H - NON-BILLABLE MEDICAL SUPP	DITES	U	130, 707		1
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14, 698		1.00
2. 00	OPERATION OF PLANT	7. 00	o	3, 529		2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	o	3, 327		3. 00
4. 00	OLCOTT	190. 03	o	37		4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	ő	11, 253, 542		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	o	o		7. 00
8.00		0.00	Ö	o		8. 00
9.00		0.00	O	O		9. 00
10.00		0.00	O	O		10.00
11. 00		0.00	0	0		11. 00

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm

		Increases			5/28/2019 12:	: 09 pm
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16.00
17. 00		0.00	O	Ö		17. 00
18.00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	Ö	Ö		23. 00
24.00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	0	Ö		29. 00
30.00		0.00	0	0		30.00
31. 00		0.00	0	0		31. 00
32.00		0.00	0	0		32. 00
33. 00 34. 00		0. 00 0. 00	0	0		33. 00 34. 00
35. 00		0.00	0	0		35. 00
36. 00		0.00	Ö	Ö		36. 00
37. 00		0.00	0	0		37. 00
38. 00		0.00	•	0		38. 00
	J - INTEREST EXPENSE		0	11, 271, 810		-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 159, 385		1.00
	0			1, 159, 385		
	K - PHARMACY RESIDENCY					
1.00	PARAMED ED PRGM-PHARMACY	23. 00	170, 049	13, 009		1. 00
2. 00	RESI DENCY	0.00		0		2. 00
2.00			170, 049			2.00
	L - PSYCH ADMIN		,	,		
1.00	OP_PSYCH_CLINIC	90.05	<u> </u>	<u>13, 2</u> 81		1. 00
	0		147, 474	13, 281		-
1. 00	M - SOFTWARE LICENSE CAP REL COSTS-MVBLE EQUIP	2.00	0	47, 421		1.00
2. 00	NEE GOSTS MIVBEE EQUIT	0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
7.00	0 — — — — —	0.00	— — ŏ	47, 421		7.00
	N - CAFETERIA		-,			
1.00	CAFETERI A	1100	<u>1, 053, 6</u> 47	<u>876, 5</u> 16		1. 00
	O SHORT TERM DISABILITY/FIA	10	1, 053, 647	876, 516		-
1.00	O - SHORT TERM DISABILITY/FLM EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 807		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	13, 689		2. 00
3.00	OPERATION OF PLANT	7. 00	0	6, 550		3. 00
4.00	HOUSEKEEPI NG	9.00	0	11, 747		4.00
5. 00 6. 00	DIETARY NURSING ADMINISTRATION	10. 00 13. 00	0	9, 840 28, 620		5. 00 6. 00
7. 00	PHARMACY	15. 00	0	10, 021		7. 00
8. 00	CENTRAL STERILIZATION	18. 01	Ö	4, 941		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	160, 935		9. 00
10. 00	INTENSIVE CARE UNIT	31.00	0	20, 704		10.00
11.00	CORONARY CARE UNIT	32.00	0	9, 721		11.00
12. 00 13. 00	SUBPROVIDER - IRF OPERATING ROOM	41. 00 50. 00	0	6, 554 34, 361		12. 00 13. 00
14. 00	RECOVERY ROOM	51.00	0	16, 002		14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	25, 983		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	28, 837		16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 544		17. 00
18. 00 19. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00	0	8, 198		18.00
17.00	(MRI)	58.00	o o	965		19. 00
20. 00	CARDIAC CATHETERIZATION	59.00	0	9, 197		20. 00
21. 00	RESPIRATORY THERAPY	65.00	0	12, 053		21. 00
						

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 12:09 pm Provider CCN: 15-0051

						pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
22. 00	PHYSI CAL THERAPY	66.00	0	75, 970	22.	2. 00
23.00	ELECTROCARDI OLOGY	69. 00	o	837	23.	3. 00
24. 00	CARDIAC REHABILITATION	76. 97	0	2, 750		1. 00
25. 00	CLINIC	90.00	0	1, 267		5. 00
26. 00	OP ONCOLOGY INFUSION CENTER	90. 01	O O	10, 424	•	5. 00
27. 00	WOUND CARE CENTER	90. 02	0	9, 322		7. 00
28. 00	OP PSYCH CLINIC	90.05	0	3, 284		3. 00
29. 00	EMERGENCY	91. 00	0	30, 966		9. 00
	1	•	0		•	
30.00	AMBULANCE SERVICES	95.00	U	54, 841	•	0.00
31.00	PROMPTCARE	190. 01	0	11, 227	· · · · · · · · · · · · · · · · · · ·	1.00
32.00	OLCOTT	190. 03	0	2, 930		2. 00
33.00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11		4, 762	33.	3. 00
	0		0	632, 849		
	P - UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7. 00	0	307, 030	1.	1. 00
2.00	PROMPTCARE	190. 01	0	93	2.	2. 00
3.00		0.00	0	0	3.	3. 00
4.00		0.00	O	0	4.	4. 00
5.00		0.00	o	0	5.	5. 00
6.00		0.00	0	0	6.	5. 00
7. 00		0.00	Ō	0		7. 00
8. 00		0.00	o o	0		3. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0	l e e e e e e e e e e e e e e e e e e e). 00). 00
			0	0		
11. 00		0.00		0	11.	1. 00
	U LOCALIDATIONAL LIFALTIL ADMINA		U	307, 123		
	R - OCCUPATIONAL HEALTH ADMIN		047.000			
1.00	ADMI NI STRATI VE & GENERAL	5.00	21 <u>7, 2</u> 93	0	1.	1. 00
	0		217, 293	0		
	S - NURSERY					
1.00	NURSERY	43.00	663, 448	65, 314	1.	1. 00
2.00		0. 00	0	0	2.	2. 00
	0		663, 448	65, 314		
	T - BEDFORD ALLOCATION					
1.00	IU HEALTH BEDFORD HOSPITAL	194. 01	1, 339, 253	556, 007	1.	1. 00
2.00		0.00	0	0	2.	2. 00
3.00		0.00	o	0	3.	3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
0.00	TOTALS — — — —	— — ••••	1, 339, 253	556, 007	0.	<i>7.</i> 00
	U - PAOLI ALLOCATION		1, 337, 233	330,007		
1. 00	IU HEALTH PAOLI HOSPITAL	194. 00	570, 440	255, 247	1	1. 00
	I U HEALIN PAULI HUSPITAL		570, 440			
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	O	0		4. 00
5.00		0. 00	0	0		5. 00
6. 00		0.00		0	6.	5. 00
	TOTALS		570, 440	255, 247		
500.00	Grand Total: Increases		4, 161, 604	97, 470, 090	500.	0. 00

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2018 To 12/31/2018

Date/Time Prepared: 5/28/2019 12:09 pm

		Decreases				5/28/2019 12:	: 09 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8.00	9. 00	10.00		
	A - BENEFITS	<u> </u>					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	683, 473	0		1.00
2.00	OPERATION OF PLANT	7.00	0	457, 604	l .		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	545, 701	l .		3. 00
4.00	DI ETARY	10.00	0	517, 438	l .		4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00	0	1, 105, 672	1		5. 00
6. 00 7. 00	PHARMACY CENTRAL STERILIZATION	15. 00 18. 01	0	774, 163 146, 377			6. 00 7. 00
8. 00	PARAMED ED PRGM-PHARMACY	23. 00	0	16, 634			8.00
0.00	RESI DENCY	20.00	J	10,001			0.00
9.00	ADULTS & PEDIATRICS	30.00	0	3, 930, 133	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	518, 954	0		10.00
11. 00	CORONARY CARE UNIT	32.00	0	373, 496	0		11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	352, 245	1		12. 00
13.00	SUBPROVI DER - I RF	41.00	0	193, 079			13.00
14.00	OPERATING ROOM	50.00	0	938, 072	1		14. 00
15. 00 16. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	0	502, 777 453, 333	l .		15. 00 16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	686, 378			17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	o	405, 459			18.00
19. 00	CT SCAN	57.00	o	106, 554			19. 00
20.00	MAGNETIC RESONANCE IMAGING	58.00	0	70, 217	l .		20.00
	(MRI)						
21. 00	CARDI AC CATHETERI ZATI ON	59.00	0	218, 673			21. 00
22. 00	RESPI RATORY THERAPY	65.00	0	367, 984	1		22. 00
23. 00	PHYSI CAL THERAPY	66.00	0	998, 246	l .		23. 00
24. 00	ELECTROCARDI OLOGY	69. 00 70. 00	0	138, 247	l .		24. 00
25. 00 26. 00	ELECTROENCEPHALOGRAPHY CARDI AC REHABI LI TATI ON	76. 97	0	30, 650 125, 431	l		25. 00 26. 00
27. 00	CLINIC	90.00	0	235, 206	1		27. 00
28. 00	OP ONCOLOGY INFUSION CENTER	90. 01	o	293, 740			28. 00
29. 00	WOUND CARE CENTER	90. 02	o	108, 940			29. 00
30.00	PAIN CLINIC	90. 03	0	42, 575	1		30.00
31.00	OP PSYCH CLINIC	90. 05	0	312, 987	0		31.00
32.00	EMERGENCY	91.00	0	805, 426	l .		32. 00
33. 00	AMBULANCE SERVICES	95. 00	0	1, 234, 536	l .		33. 00
34. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	25, 780	0		34. 00
35. 00	CANTEEN PROMPTCARE	190. 01	o	237, 656	o		35. 00
36. 00	OLCOTT	190.01	0	74, 156	1		36.00
37. 00	HME STORE	190. 07	0	143			37. 00
38. 00	CLINICAL TRIALS	190. 09	0	29, 292			38. 00
39. 00	COMMUNITY HEALTH SERVICES	190. 11	o	694, 932	l .		39. 00
	0		0	18, 752, 359			
	B - CAPITAL RELATED				1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 193	I .		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 566, 974	l .		2.00
3. 00 4. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	6, 586, 187 10, 469	l .		3. 00 4. 00
5.00	HOUSEKEEPI NG	9.00	0	8, 124	l .		5. 00
6.00	DI ETARY	10.00	o	35, 164	l .		6. 00
7.00	NURSING ADMINISTRATION	13.00	0	208, 975	l .		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	559			8. 00
9.00	PHARMACY	15. 00	0	135, 529	0		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 774			10.00
11. 00	CENTRAL STERILIZATION	18. 01	0	59, 822			11. 00
12.00	ADULTS & PEDIATRICS	30.00	0	190, 549			12.00
13.00	INTENSIVE CARE UNIT	31. 00 32. 00	0	57, 102 42, 548			13.00
14. 00 15. 00	CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	35. 00 35. 00	0	42, 548 59, 974			14. 00 15. 00
16. 00	SUBPROVI DER - I RF	41.00	0	479			16. 00
17. 00	OPERATING ROOM	50.00	0	1, 007, 614			17. 00
18. 00	DELIVERY ROOM & LABOR ROOM	52.00	o	82, 146			18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	720, 634			19. 00
20.00	RADI OLOGY-THERAPEUTI C	55.00	0	526, 733			20. 00
21. 00	CT SCAN	57.00	0	352, 949	l .		21. 00
22. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	593, 697	0		22. 00
22.00	(MRI)	F0 00		204 005			22.00
23. 00 24. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	381, 895 70, 772	l .		23. 00 24. 00
24. 00 25. 00	RESPIRATORY THERAPY	65.00	0	70, 772 141, 839	l .		25. 00
26. 00	PHYSICAL THERAPY	66.00	0	29, 814			26. 00
27. 00	ELECTROCARDI OLOGY	69.00	o	158, 900			27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70.00	Ö	42, 388			28. 00
		<u>'</u>	<u>'</u>		<u>'</u>		

Provider CCN: 15-0051

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 12:09 pm

						5/28/2019 12:	:09 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
29. 00	OP PHARMACY	73. 01	0	7, 781	0		29. 00
30.00	RENAL DIALYSIS	74.00	0	33	0		30. 00
31.00	CARDIAC REHABILITATION	76. 97	0	5, 151	0		31.00
32.00	CLINIC	90.00	0	10, 363	0		32. 00
33.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	191, 747	ol		33.00
34.00	WOUND CARE CENTER	90. 02	0	29, 751	O		34.00
35. 00	PAIN CLINIC	90. 03	0		o		35. 00
36. 00	OP PSYCH CLINIC	90.05	0	766	1		36. 00
37. 00	EMERGENCY	91.00	0	350, 749			37. 00
38. 00	AMBULANCE SERVICES	95.00	0	395, 389			38.00
39. 00			0		1		39.00
39.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	U	2, 674	U		39.00
40.00	CANTEEN	100.01		40.040			40.00
40. 00	PROMPTCARE	190. 01	0	12, 963			40.00
41. 00	OLCOTT	190. 03	0	114			41. 00
42. 00	HME STORE	190. 07	0	2, 054			42. 00
43. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	0	643			43. 00
	0		0	14, 090, 253			
	C - BILLABLE MEDICAL SUPPLIES	5					
1.00	NURSING ADMINISTRATION	13.00		17, 263	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00		2, 719	0		2. 00
3.00	PHARMACY	15.00		5, 083	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00		110, 555	o		4.00
5.00	INTENSIVE CARE UNIT	31.00		32, 942	O		5. 00
6. 00	CORONARY CARE UNIT	32.00		4, 866	o		6. 00
7. 00	NEONATAL INTENSIVE CARE UNIT	35.00		13, 456			7. 00
8. 00	SUBPROVI DER - I RF	41.00		28			8.00
9. 00							9. 00
	OPERATING ROOM	50.00		4, 743, 709			1
10.00	RECOVERY ROOM	51.00		10, 183			10.00
11. 00	DELIVERY ROOM & LABOR ROOM	52.00		208, 833			11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00		661, 095			12. 00
13. 00	RADI OLOGY-THERAPEUTI C	55. 00		3, 941	0		13. 00
14. 00	CT SCAN	57. 00		20, 417			14. 00
15. 00	MAGNETIC RESONANCE IMAGING	58. 00		2, 413	0		15. 00
	(MRI)						
16.00	CARDIAC CATHETERIZATION	59.00		3, 310, 140	0		16. 00
17.00	RESPIRATORY THERAPY	65.00		14, 723	0		17. 00
18. 00	PHYSI CAL THERAPY	66.00		23, 414	1		18. 00
19. 00	ELECTROENCEPHALOGRAPHY	70.00		7, 869			19. 00
20. 00	RENAL DIALYSIS	74.00		9, 176			20.00
21. 00	CARDI AC REHABI LI TATI ON	76. 97		150	o		21. 00
22. 00	CLINIC	90.00		701	o		22. 00
23. 00	OP ONCOLOGY INFUSION CENTER	90.01		188, 954			23. 00
24. 00	WOUND CARE CENTER	90.01		1	0		24. 00
				14, 691			1
25. 00	PAIN CLINIC	90. 03		3, 005	0		25. 00
26. 00	OP PSYCH CLINIC	90. 05		192	0		26. 00
27. 00	EMERGENCY	91.00		51, 079			27. 00
28. 00	AMBULANCE SERVICES	95. 00		28, 557	0		28. 00
29. 00	PROMPTCARE	190.01		1 <u>0, 9</u> 89	0		29. 00
	0		0	9, 501, 143			
	D - BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		87, 083	0		1. 00
2.00	NURSING ADMINISTRATION	13. 00		1	0		2. 00
3.00	PHARMACY	15. 00		19, 778, 385	O		3. 00
4. 00	ADULTS & PEDIATRICS	30.00		196	1		4. 00
5. 00	INTENSIVE CARE UNIT	31.00		85			5. 00
6.00	OPERATING ROOM	50.00		67, 017			6. 00
7. 00	DELIVERY ROOM & LABOR ROOM	52. 00		8, 972			7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00		21, 683	1		8.00
							1
9.00	RADI OLOGY-THERAPEUTI C	55.00		16, 858			9.00
10.00	CT SCAN	57.00		121, 709			10.00
11. 00	MAGNETIC RESONANCE I MAGING	58. 00		62, 087	0		11. 00
40	(MRI)						40
12. 00	CARDI AC CATHETERI ZATI ON	59.00		55, 083			12. 00
13. 00	PHYSI CAL THERAPY	66.00		96			13. 00
14. 00	ELECTROCARDI OLOGY	69. 00		353, 087			14. 00
15. 00	RENAL DIALYSIS	74.00		222			15. 00
16.00	CARDIAC REHABILITATION	76. 97		48	0		16. 00
17.00	CLINIC	90.00		13, 315	o		17. 00
18.00	OP ONCOLOGY INFUSION CENTER	90. 01		8, 816			18. 00
19. 00	WOUND CARE CENTER	90. 02		16, 566			19. 00
20. 00	PAIN CLINIC	90. 03		30, 283			20.00
21. 00	EMERGENCY	91.00		1, 718			21.00
22. 00	AMBULANCE SERVICES	95.00		46, 166			22. 00
23. 00	PROMPTCARE	190. 01		72, 375	1		23. 00
23.00	I NOW TOAKL	170.01		12,373	ı V		

Provider CCN: 15-0051

| Period: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 12:09 pm

						5/28/2019 1	12: 09 pm
		Decreases		0.11			
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
24. 00	6. 00 COMMUNITY HEALTH SERVICES	7. 00 190. 11	8. 00	9. 00 7, 536	10. 00		24. 00
24.00	O DEALTH SERVICES				— — ^Ч		24.00
	E - IMPLANTS SUPPLIES		<u> </u>	20, 107, 301			
1.00	NURSING ADMINISTRATION	13. 00	I	3, 505	0		1.00
2.00	CENTRAL STERILIZATION	18. 01		211	o		2. 00
3.00	ADULTS & PEDIATRICS	30.00		4, 004	0		3. 00
4.00	INTENSIVE CARE UNIT	31. 00		1, 221	0		4. 00
5.00	CORONARY CARE UNIT	32. 00		394	0		5. 00
6. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		1, 766	0		6. 00
7. 00	SUBPROVI DER - I RF	41.00		43	0		7. 00
8. 00	OPERATING ROOM	50.00		12, 023, 358	0		8. 00
9.00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51.00		194	0		9. 00
10. 00 11. 00	RADI OLOGY-DI AGNOSTI C	54. 00 55. 00		280, 172	0		10. 00 11. 00
12. 00	CT SCAN	57. 00		1, 781	0		12. 00
13. 00	CARDI AC CATHETERI ZATI ON	59.00		4, 596, 607	o		13. 00
14. 00	ELECTROENCEPHALOGRAPHY	70.00		375	o		14. 00
15. 00	OP ONCOLOGY INFUSION CENTER	90. 01		4, 725	o		15. 00
16.00	EMERGENCY	91.00	•	1, 706	O		16. 00
	0 — — — — —			16, 920, 065			
	F - LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	20, 160	10		1. 00
2.00	OPERATION OF PLANT	7. 00	0	228, 162	10		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	308, 368	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 596	0		4. 00
5.00	LABORATORY	60.00	0	21, 824	0		5. 00
6.00	RESPIRATORY THERAPY	65.00	0	22, 213	0		6. 00
7.00	PHYSICAL THERAPY	66.00	0	424, 592	0		7. 00
8. 00 9. 00	ELECTROENCEPHALOGRAPHY OP ONCOLOGY INFUSION CENTER	70. 00 90. 01	0	1, 372 55, 800	0		8. 00 9. 00
10. 00	WOUND CARE CENTER	90.01	0	71, 012	0		10.00
11. 00	PAIN CLINIC	90. 03	0	20, 290	0		11.00
12. 00	AMBULANCE SERVICES	95.00	Ö	158, 722	0		12.00
13. 00	PROMPTCARE	190. 01	0	32, 621	o		13. 00
14.00	FOUNDATI ON	190. 05	0	68, 767	O		14. 00
15.00	COMMUNITY HEALTH SERVICES	190. 11	О	58, 433	o		15. 00
	0		0	1, 499, 932			
	G - NON-BILLABLE DRUGS						
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	230	0		1. 00
2.00	NURSING ADMINISTRATION	13.00	0	1, 361	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	199, 952	0		3.00
4. 00 5. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00	0	87, 855 33, 416	0		4. 00 5. 00
6.00	NEONATAL INTENSIVE CARE UNIT	32. 00 35. 00	0	11, 107	O O		6. 00
7. 00	SUBPROVI DER - I RF	41.00	0	1, 174	o		7. 00
8. 00	OPERATING ROOM	50.00	0	170, 837	Ö		8. 00
9. 00	RECOVERY ROOM	51. 00	o	85, 770	o		9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	О	12, 011	o		10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	O	16, 807	O		11. 00
12.00	RADI OLOGY-THERAPEUTI C	55. 00	0	24, 132	0		12. 00
13.00	CT SCAN	57. 00	0	220	0		13. 00
14.00	MAGNETIC RESONANCE I MAGING	58. 00	0	241	0		14. 00
45.00	(MRI)	50.00		00.400			45.00
15. 00	CARDI AC CATHETERI ZATI ON	59.00	0	20, 628	0		15. 00
16.00	LABORATORY THERADY	60. 00 65. 00	0	2, 263 6, 830	0		16. 00 17. 00
17. 00 18. 00	RESPI RATORY THERAPY ELECTROCARDI OLOGY	69. 00	0	1, 712	0		18.00
19. 00	RENAL DI ALYSI S	74.00	0	13, 089	0		19. 00
20. 00	CARDI AC REHABI LI TATI ON	76. 97	0	2	o		20. 00
21. 00	CLINIC	90.00	o	11, 872	o		21. 00
22.00	OP ONCOLOGY INFUSION CENTER	90. 01	O	3, 788	o		22. 00
23.00	WOUND CARE CENTER	90. 02	0	6, 491	O		23. 00
24.00	PAIN CLINIC	90. 03	0	202	0		24. 00
25. 00	EMERGENCY	91.00	o	1, 987	o		25. 00
26. 00	AMBULANCE SERVICES	95.00	0	24, 425	o		26. 00
27. 00	PROMPTCARE	190. 01	0	42	0		27. 00
28. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	•	545	0		28. 00
	U NON BLLLARI E MEDICAL CUE	NII EC	0	738, 989			_
1 00	H - NON-BILLABLE MEDICAL SUPP	4. 00	ما	4 017	ما		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT HOUSEKEEPING	4. 00 9. 00	0	4, 017 56, 270	0		1. 00 2. 00
3.00	DI ETARY	10. 00	0	17, 367	0		3.00
4. 00	NURSING ADMINISTRATION	13. 00	0	32, 312	o		4. 00
5. 00	PHARMACY	15. 00	Ö	143, 907	o		5. 00
-	•		-1	• • •	- 1		

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0051 Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

						lo 12/31/2018 Date/lime Pr 5/28/2019 12	
		Decreases		<u>'</u>			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
/ 00	6. 00	7.00	8. 00	9. 00	10.00		(00
6. 00 7. 00	MEDICAL RECORDS & LIBRARY CENTRAL STERILIZATION	16. 00 18. 01	0	45 302, 491	0	1	6. 00 7. 00
8. 00	PARAMED ED PRGM-PHARMACY	23. 00	ő	657	0	l .	8. 00
	RESI DENCY]		_		
9.00	ADULTS & PEDIATRICS	30.00	0	1, 776, 043	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	418, 984			10. 00
11.00	CORONARY CARE UNIT	32.00	0	218, 984			11.00
12. 00 13. 00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	35. 00 41. 00	0	175, 895			12. 00 13. 00
14. 00	OPERATING ROOM	50.00	0	56, 483 4, 333, 499	_		14. 00
15. 00	RECOVERY ROOM	51.00	ő	112, 389			15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	365, 982			16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	О	122, 315			17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	0	492, 156			18. 00
19. 00	CT SCAN	57.00	0	141, 305			19.00
20. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	11, 722	0		20. 00
21. 00	(MRI) CARDIAC CATHETERIZATION	59.00	o	308, 356	0		21. 00
22. 00	RESPIRATORY THERAPY	65.00	ő	479, 888			22. 00
23. 00	PHYSI CAL THERAPY	66.00	0	21, 257			23. 00
24.00	ELECTROCARDI OLOGY	69. 00	0	37, 429	0		24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	56, 653			25. 00
26. 00	RENAL DI ALYSI S	74.00	0	13, 694			26. 00
27. 00	CARDI AC REHABI LI TATI ON	76. 97	0	7, 611	0		27. 00
28. 00 29. 00	CLINIC OP ONCOLOGY INFUSION CENTER	90. 00 90. 01	0	15, 034 157, 136			28. 00 29. 00
30.00	WOUND CARE CENTER	90.01	0	77, 610	_		30.00
31. 00	PAIN CLINIC	90.03	ő	17, 411	0		31.00
32.00	OP PSYCH CLINIC	90. 05	O	918	0		32. 00
33.00	EMERGENCY	91.00	0	1, 015, 293	0		33. 00
34.00	AMBULANCE SERVICES	95. 00	0	203, 368			34. 00
35. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	107	0		35. 00
36. 00	CANTEEN PROMPTCARE	190. 01	o	67, 071	0		36. 00
37. 00	CLINICAL TRIALS	190.09	ő	68	-		37. 00
38. 00	COMMUNITY HEALTH SERVICES	19011	0	10, 083	0		38. 00
	0		0	11, 271, 810			
1 00	J - INTEREST EXPENSE	112.00	ما	1 150 205	11		1 00
1. 00	INTEREST EXPENSE	113.00	0	<u>1,</u> 15 <u>9, 3</u> 85 1, 159, 385			1.00
	K - PHARMACY RESIDENCY		<u> </u>	1, 107, 000			
1.00	PHARMACY	15. 00	155, 121	11, 867	0		1. 00
2.00	CLINIC	90.00	14, 928				2. 00
	O L - PSYCH ADMIN		170, 049	13, 009			-
1.00	ADULTS & PEDIATRICS	30.00	147, 474	13, 281	0		1.00
	0		147, 474				
	M - SOFTWARE LICENSE				T		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	484			1.00
2. 00 3. 00	NURSING ADMINISTRATION ADULTS & PEDIATRICS	13. 00 30. 00	0	4, 059 2, 193			2. 00 3. 00
4.00	OPERATING ROOM	50.00	0	2, 193 14, 551	0		4. 00
5. 00	AMBULANCE SERVICES	95.00	ő	5, 491	0		5. 00
6.00	PROMPTCARE	190. 01	o	5, 643		l .	6. 00
7.00	OLCOTT	<u> </u>	0	1 <u>5, 0</u> 00	0		7. 00
	0		0	47, 421			-
1. 00	N - CAFETERIA DI ETARY	10.00	1, 053, 647	876, 516	0		1.00
1.00	0		1, 053, 647	876, 516			1.00
	O - SHORT TERM DISABILITY/FLM	MA	,				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 807	0			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	13, 689	0	-	l .	2. 00
3.00	OPERATION OF PLANT	7.00	6, 550	0	0	l .	3. 00
4. 00 5. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	11, 747 9, 840	0	0	l .	4. 00 5. 00
6.00	NURSING ADMINISTRATION	13. 00	28, 620	0	0		6. 00
7. 00	PHARMACY	15. 00	10, 021	0	0		7. 00
8. 00	CENTRAL STERILIZATION	18. 01	4, 941	0	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	160, 935	0	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	20, 704	0	0		10.00
11.00	CORONARY CARE UNIT	32.00	9, 721	0	0		11.00
12. 00 13. 00	SUBPROVIDER - IRF OPERATING ROOM	41. 00 50. 00	6, 554 34, 361	0			12. 00 13. 00
14. 00	RECOVERY ROOM	51.00	16, 002	-			14. 00
	•	. '			•		<u> </u>

Provider CN: 15-005	Heal th	Financial Systems	I	U HEALTH BLOOMII	NGTON HOSPITAL		In Lie	of Form CMS-	-2552-10
Cost Genter	RECLAS	RECLASSI FI CATI ONS			Provi der CCN:			Worksheet A-	6
Cost Center								Date/Time Pro	epared:
Cost Center			Роспосос					5/28/2019 12:	:09 pm
C. OO 7.00 8.00 9.00 10.00 115.00 115.00 16.00 15.00 16.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 RADIOLOGY-DERAPEUTIC 54.00 28.837 0 0 0 17.00 RADIOLOGY-DERAPEUTIC 55.00 2.544 0 0 17.00 17.00 RADIOLOGY-DERAPEUTIC 55.00 2.544 0 0 0 17.00		Cost Center		Salary	Other Wks	st A-7 Ref			
15.00 DELLYERY ROOM & LABOR ROOM 52.00 25,983 0 0 15.00 17.00							-		
17.00 RADIOLOGY-THERAPEUTIC 55.00 2,544 0 0 17.00 19.00 MAGNETIC RESONANCE IMAGING 58.00 966 0 0 0 19.00 MAGNETIC RESONANCE IMAGING 58.00 966 0 0 0 19.00 MAGNETIC RESONANCE IMAGING 58.00 966 0 0 0 20.00 20.00 0 0 0 21.00 RESPIRATION THERAPY 65.00 12.053 0 0 0 22.00 PAYSICAL THERAPY 66.00 75.970 0 0 22.00 23.00 ELECTROCARDIOLOSY 69.00 837 0 0 22.00 24.00 CARDICAL THERAPY 66.00 75.970 0 0 22.00 25.00 CLINIC 90.00 1.267 0 0 22.00 26.00 0 PONCOLOCY INFUSION CENTER 90.01 10.424 0 0 22.00 27.00 MOUND CARE CENTER 90.02 9.322 0 0 0 27.00 28.00 0 PESVIC CLINIC 90.08 3.284 0 0 22.00 29.00 0 EMERCENCY 90.08 3.284 0 0 22.00 20.00 DESCRIPTION CENTER 90.01 11.227 0 0 31.00 20.00 0 EMERCENCY 90.08 3.284 0 0 22.00 20.00 DESCRIPTION CENTER 90.01 11.227 0 0 31.00 20.00 0 EMERCENCY 90.08 3.284 0 0 22.00 20.00 0 0 0 32.00 33.00 20.00 0 0 0 0 33.00 20.00 0 0 0 0 0 33.00 20.00 0 0 0 0 0 33.00 20.00 0 0 0 0 0 0 33.00 20.00 0 0 0 0 0 0 33.00 20.00 0 0 0 0 0 0 0 33.00 20.00 0 0 0 0 0 0 0 0 0	15. 00		52.00	25, 983	0	C			15. 00
18.00 CT SCAN 57.00 8.198 0 0 18.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19	16.00	RADI OLOGY-DI AGNOSTI C	54.00	28, 837	0	C			16. 00
19.00 MACRITIC RESONANCE IMAGING 58.00 965 0 0	17.00	RADI OLOGY-THERAPEUTI C	55.00	2, 544	0	C)		17. 00
UNRIL CAPITAC CATHETER IZATION 59.00 9,197 0 0 22.00			57. 00		0	C)		1
21.00 RESPIRATORY THERAPY 6.6.00 12,053 0 0 21.00 0 22.00 22.00 PHYSICAL THERAPY 6.6.00 75,707 0 0 0 22.00 23.00 0 24.00 23.00 0 24.00 23.00 0 24.00 23.00 0 23.00 0 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 25.00 25.00 25.00 25.00 25.00 25.00 26.00 27.00 25.00 27.00 26.00 27.00	19. 00	(MRI)		965	0	С			19. 00
22.00 HYSICAL THERAPY		CARDI AC CATHETERI ZATI ON	59. 00	9, 197	0	C)		20. 00
23.00 CLICATE CARDIOLOGY 69.00 837 0 0 22.00 0 25.00 CLINIC 90.01 1.267 0 0 0 25.00 CLINIC 90.00 1.267 0 0 0 25.00 CLINIC 90.00 1.267 0 0 0 25.00 27.00 MOUND CARE CENTER 90.01 10.424 0 0 0 25.00 27.00 MOUND CARE CENTER 90.01 10.424 0 0 0 22.00 27.00 MOUND CARE CENTER 90.02 9.322 0 0 0 27.00 28.00 0 PSYCH CLINIC 90.05 3.284 0 0 0 0 28.00 0 PSYCH CLINIC 90.05 3.284 0 0 0 0 28.00 0 PSYCH CLINIC 90.05 3.284 0 0 0 0 29.00 30.00 MOUND CARE CENTER 90.01 11.227 0 0 0 30.00 30.00 MOUND ARE SERVICES 95.00 5.8, 841 0 0 0 30.00 30.00 31.00 PROMPTCARE 190.01 11.227 0 0 0 31.00 30.00 31.00 COMMUNITY HALTH SERVICES 190.11 4.7, 62 0 0 0 33.00 32.00 33.00 COMMUNITY HEALTH SERVICES 190.11 4.7, 62 0 0 0 33.00 33.00 COMMUNITY HEALTH SERVICES 190.11 4.7, 62 0 0 0 33.00 33.00 33.00 COMMUNITY HEALTH SERVICES 30.00 0 17 0 2.00 ADULTS & ROUND STATE SERVICES 30.00 0 17 0 2.00 ADULTS & ROUND STATE SERVICES 30.00 0 17 0 2.00 ADULTS & ROUND STATE SERVICES 30.00 0 17 0 2.00 ADULTS & ROUND STATE SERVICES 30.00 0 14, 096 0 3.00 ADULTS & ROUND STATE SERVICES 30.00 0 14, 096 0 3.00 ADULTS ARE SERVICES 30.00 0 14, 096 0 3.00 ADULTS ARE SERVICES 30.00 0 14, 096 0 3.00 ADULTS ARE SERVICES 30.00 0 14, 096 0 3.00 ADULTS ARE SERVICES 30.00 0 14, 096 0 3.00 ADULTS ARE SERVICES 30.00 0 14, 096 0 3.00 ADULTS ARE SERVICES 30.00 0 18, 030 0 3.00 ADULTS ARE SERVICES 30.00 ADULTS ARE SERVICES 30.00 ADULTS ARE SERVICES 30.00 ADULTS ARE SERVICE		1			0				1
24. 00 CARDIAC REHABILITATION 76. 97 2, 750 0 0 24. 00 25. 00 26. 00 0 0 0 0 0 0 0 26. 00 0 0 0 0 0 26. 00 0 0 0 0 26. 00 0 0 0 26. 00 0 0 26. 00 0 26. 00 0 26. 00 0 27. 00 0 0 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 29. 00 0 0 0 0 0 0 0 0 0					0				
25.00 CLINIC 90.00 1.267 0 0 25.00					0				1
26. 00 OP ONCOLOGY INFUSION CENTER 90. 01 10. 424 0 0 22. 00 27. 00 28. 00 OP PSYCH CLINIC 90. 05 3. 284 0 0 0 28. 00 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 29. 00 0 0 0 0 0 0 0 0 0					-		1		1
27. 00 WOUND CARE CENTER					<u> </u>				1
28. 00 OP PSYCH CLINIC 90. 05 3. 284 0 0 29. 00 29. 00 EMBRUANCE SERVICES 95. 00 54. 841 0 0 30. 00 30. 00 AMBULANCE SERVICES 95. 00 54. 841 0 0 33. 00 32. 00 OLOTT 190. 03 2. 930 0 0 32. 00 33. 00 OLOTT 190. 03 2. 930 0 0 32. 00 33. 00 OLOTT 190. 01 17. 227 0 0 0 32. 00 33. 00 OLOTT 190. 01 4. 762 0 0 0 33. 00 P					0				
29.00 BMERGENCY 91.00 30.966 0 0 29.00 30.00 30.00 30.00 31.00 PROMPTCARE 190.01 11.227 0 0 0 31.00 32.00 32.00 0 0 0 33.00 33.00 0 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 0 33.00 0 0 0 0 0 0 0 0 0					0	_	1		1
30.00 AMBULANCE SERVICES					0	_	1		1
31.00 PROMPITCARE 190.01 11.227 0 0 33.00 32.00 32.00 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 33.00 0 0 0 0 33.00 0 0 0 0 0 0 0 0 0		1			0		1		1
1.00					0	-			1
33.00 COMMUNITY HEALTH SERVICES 190.11 4.762 0 0 0 0 0 0 0 0 0					0				1
1.00		1			0				1
1.00	33.00	O SERVICES					<u>'</u>		33.00
1.00		P - UTILITIES EXPENSE		002,017	<u> </u>				
2.00 ADULTS & PEDIATRICS 30.00 0 17 0 2.00 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 14.096 0 4.00 RADIOLOGY-THERAPEUTIC 55.00 0 149.480 0 5.00 PHYSICAL THERAPY 66.00 0 28.825 0 7.00 PHYSICAL THERAPY 66.00 0 28.825 0 7.00 PHYSICAL THERAPY 66.00 0 28.825 0 7.00 PAIN CLINIC 90.03 0 6.359 0 7.00 PAIN CLINIC 90.03 0 6.359 0 7.00 PAIN CLINIC 90.03 0 6.359 0 7.00 PAIN CLINIC 90.02 0 33.660 0 8.00 AMBULANCE SERVICES 99.500 0 9.119 0 9.00 RENTAL PROPERTIES 190.02 0 33.660 0 9.00 FOUNDATION 190.05 0 9.119 0 11.00 COMMUNITY HEALTH SERVICES 190.11 0 28.316 0 0 0 0 307.123 1.00 PROMPTCARE 190.11 217.293 0 0 217.293 0 0 217.293 0 0 20.327 4.288 0 0 20.00 20.327 4.288 0 0 20.00 20.327 4.288 0 0 20.00 20.327 4.288 0 0 20.00 20.327 4.288 0 0 20.00 20.327 4.288 0 0 0 0 663.448 655.314 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 36.988 26.537 0 3.00 NURSING ADMINISTRATION 13.00 512.730 192.128 0 3.00 PHARMACY 15.00 294.017 74.620 0 0 0 0 0 0 0 0 0	1.00		4.00	0	2, 053	C			1.00
3. 00 RADI OLOGY-DI AGNOSTI C				•	,				1
A . 00		RADI OLOGY-DI AGNOSTI C		•			l .		1
6. 00 PO NOCOLGCY INFUSION CENTER 99. 01 0 4, 062 0 7. 00 PAIN CLINIC 99. 03 0 6, 359 0 7. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 8. 00 9. 00 0 31, 136 0 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 10. 00 1	4.00	RADI OLOGY-THERAPEUTI C	55.00	0	149, 480	C			4. 00
7. 00 PAIN CLINIC 90. 03 0 6, 359 0 8. 00 8. 00 8. 00 9. 00 RUNTAL PROPERTIES 95. 00 0 31, 136 0 9. 00 9. 00 10. 00 FOUNDATION 190. 05 0 9, 119 0 10. 00 10. 00 10. 00 FOUNDATION 190. 05 0 9, 119 0 10. 00 1	5.00	PHYSI CAL THERAPY	66.00	0	28, 825	C			5. 00
8. 00 AMBULANCE SERVICES 95. 00 0 31, 136 0 9. 00	6.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	4, 062	C			6. 00
9.00 RENTAL PROPERTIES 190.02 0 33,660 0 9.00 10.00 FOUNDATION 190.05 0 9,119 0 11.00 O O O O O O O	7.00		90. 03	0	6, 359	C			7. 00
10.00				0		C)		1
11.00 COMMUNITY HEALTH SERVICES 190.11 0 28,316 0 0 307,123		1		0					1
1.00 PROMPTICARE 190.01 217,293 0 0 0 0 0 0 0 0 0		1		-1			1		1
R - OCCUPATI ONAL HEALTH ADMIN	11. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11				0		11. 00
1.00 PROMPTCARE		O D. COOLIDATI ONAL UEALTH ADMIA		0	307, 123				
Color Col	1 00			217 202					1 00
S - NURSERY	1.00	PROMPTCARE					4		1.00
1.00 ADULTS & PEDIATRICS 30.00 643, 121 61,026 0 0 0 0 0 0 0 0 0		C NIIDSEDV		217, 293	U				
DELI VERY ROOM & LABOR ROOM	1 00		30.00	643 121	61 026				1 00
T - BEDFORD ALLOCATION T - BEDFORD ALLOCAT							1		4
T - BEDFORD ALLOCATION	2.00	0					1		2.00
1. 00 EMPLOYEE BENEFITS DEPARTMENT		T - BEDFORD ALLOCATION		000/110	00,011				
2.00 ADMI NI STRATI VE & GENERAL 5.00 455, 490 245, 175 0 3.00 3.00 0 0 0 0 0 0 0 0 0	1.00		4.00	36, 988	26, 537	C			1.00
3.00 NURSING ADMINISTRATION 13.00 512, 730 192, 128 0 4.00 PHARMACY 15.00 294, 017 74, 620 0 4.00 5.00 CLINIC 90.00 40, 028 17, 547 0 5.00 U - PAOLI ALLOCATION CAP REL COSTS-MVBLE EQUIP 2.00 0 9, 375 9 1.00 2.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 19, 319 13, 860 0 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 215, 268 117, 719 0 3.00 4.00 NURSING ADMINISTRATION 13.00 221, 537 81, 439 0 4.00 5.00 PHARMACY 15.00 98, 905 26, 098 0 5.00 6.00 CLINIC 90.00 15, 411 6, 756 0 6.00 TOTALS 5.00 255, 247									1
4.00 PHARMACY 15.00 294,017 74,620 0 4.00 5.00 CLINIC 90.00 40,028 17,547 0 5.00 U - PAOLI ALLOCATION	3.00	NURSING ADMINISTRATION				C			3. 00
TOTALS	4.00		15. 00	294, 017	74, 620	C			4. 00
U - PAOLI ALLOCATION	5.00	CLINIC	90.00	40, 028	17, 547	C			5. 00
1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 9, 375 9 2. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 19, 319 13, 860 0 3. 00 ADMI NI STRATI VE & GENERAL 5. 00 215, 268 117, 719 0 3. 00 4. 00 NURSI NG ADMI NI STRATI ON 13. 00 221, 537 81, 439 0 4. 00 5. 00 PHARMACY 15. 00 98, 905 26, 098 0 5. 00 6. 00 CLI NI C 90. 00 15, 411 6, 756 0 6. 00 TOTALS 570, 440 255, 247				1, 339, 253	556, 007				
2.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 19,319 13,860 0 3.00 ADMI NI STRATI VE & GENERAL 5.00 215,268 117,719 0 4.00 NURSI NG ADMI NI STRATI ON 13.00 221,537 81,439 0 4.00 5.00 PHARMACY 15.00 98,905 26,098 0 5.00 6.00 CLI NI C 90.00 15,411 6,756 0 TOTALS 570,440 255,247			,						
3.00 ADMI NI STRATI VE & GENERAL 5.00 215, 268 117, 719 0 4.00 NURSI NG ADMI NI STRATI ON 13.00 221, 537 81, 439 0 4.00 5.00 PHARMACY 15.00 98, 905 26, 098 0 5.00 6.00 CLI NI C 90.00 15, 411 6, 756 0 6.00 TOTALS 570, 440 255, 247									
4. 00 NURSI NG ADMI NI STRATI ON 13. 00 221, 537 81, 439 0 4. 00 5. 00 PHARMACY 15. 00 98, 905 26, 098 0 5. 00 6. 00 CLI NI C 90. 00 15, 411 6, 756 0 TOTALS 570, 440 255, 247							l .		1
5. 00 PHARMACY 15. 00 98, 905 26, 098 0 5. 00 6. 00 CLINIC 90. 00 15, 411 6, 756 0 6. 00 TOTALS 570, 440 255, 247							l .		1
6. 00 CLINIC							l .		
TOTALS 570, 440 255, 247		1							1
	6.00		90.00				4		6.00
500. 00 gi anu rotar. Decreases 4, 174, 435 40, 837, 241 500. 00	500 00						+		500.00
	500.00	Joi and Total. Decleases		4, 174, 403	70, 037, 241		I		1 300.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0051

					To 12/31/2018		
				Acqui si ti ons		372072019 12.	О У ріп
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	19, 741, 447	0		0	0	1. 00
2.00	Land Improvements	2, 058, 207	0		0	0	2. 00
3.00	Buildings and Fixtures	150, 733, 671	0		0	0	3. 00
4.00	Building Improvements	11, 338, 115	32, 782		0 32, 782	43, 252	1
5.00	Fi xed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	176, 622, 236	8, 419, 906		0 8, 419, 906	46, 271, 604	
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	360, 493, 676	8, 452, 688		0 8, 452, 688	46, 314, 856	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	360, 493, 676	8, 452, 688		0 8, 452, 688	46, 314, 856	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	19, 741, 447	0				1.00
2.00	Land Improvements	2, 058, 207	0				2.00
3.00	Buildings and Fixtures	150, 733, 671	0				3. 00
4.00	Building Improvements	11, 327, 645	0				4.00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	138, 770, 538	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	322, 631, 508	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	322, 631, 508	O				10. 00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0051	Peri od:	Worksheet A-7	
				From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	pared.
					5/28/2019 12:	
		Sl	JMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	
DART III DESCRIPTION OF ANOTHER EDGIL	9.00	10.00	11.00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM W	DRKSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00 3. 00
3.00 Total (sum of lines 1-2)	SUMMARY 0	E CADITAI		0 0	0	3.00
	SUMMART	r CAPITAL				
Cost Center Description	Other	Total (1) (sum	-			
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM W	ORKSHEET A, COLUM	N 2, LINES 1 a	ind 2			1
1.00 CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	1			2. 00
3.00 Total (sum of lines 1-2)	0	0	1			3.00

Heal th	n Financial Systems II	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C			Peri od: Worksheet A-7 From 01/01/2018 Part III To 12/31/2018 Date/Time Pre 5/28/2019 12:	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FIXT	183, 860, 970		183, 860, 97	0 0. 569879	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	138, 770, 538		138, 770, 53			2. 00
3.00	Total (sum of lines 1-2)	322, 631, 508		322, 631, 50			3. 00
0.00	Trotal (Sam Cr Tribo 1 2)		TION OF OTHER (_	F CAPITAL	0.00
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS	1 -	1			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 9, 591, 744		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 11, 339, 136		2.00
3.00	Total (sum of lines 1-2)	0	0	IMMADY OF CARL	0 20, 930, 880	1, 499, 932	3. 00
			St	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
			Í	ĺ	d Costs (see	through 14)	
					instructions)	,	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	-4, 922, 185	0		0 0	5, 805, 572	1.00
2 00	CAR REL COSTS MARIE FOLLID		1 ^	I	0 47 421	11 750 476	2 00

0 -4, 922, 185

0 0 0

47, 421 47, 421

 5, 805, 572
 1.00

 11, 750, 476
 2.00

 17, 556, 048
 3.00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: From 01/01/2018 Provider CCN: 15-0051

				Expense Classification on	Worksheet A	5/28/2019 12:0	09 pm
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 A	2. 00 -5. 327, 021	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 11	1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		O	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		О		0. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		О		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		O		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9.00	Parking Lot (chapter 21)	4.0.2	0		0. 00	0	
10. 00	Provider-based physician adjustment	A-8-2	-20, 893, 622			U	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	30, 700, 744			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		o		0.00	0	14.00
15. 00	Rental of quarters to employee and others		ď		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17 00	pati ents				0.00		17.00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health		О		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty				2.23		
22. 00	charges (chapter 21) Interest expense on Medicare		О		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	o	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	o	PHYSI CAL THERAPY	66.00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
27.00	(chapter 21)			CAD DEL COCTO DIDO A FLVT	1 00		27.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		o,	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	Ols	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest MISCELLANEOUS INCOME	В	1, 475, 742ll	EMPLOYEE BENEFITS DEPARTMENT	4. 00	ol	33. 00
	· · · · · · · · · · · · · · · · · · ·		,			. "	·

Provider CCN: 15-0051 Worksheet A-8 From 01/01/2018 | Date/Time Prepared:

5	5/28/2019 12:	
Expense Classification on Worksheet A		
To/From Which the Amount is to be Adjuste		
Cost Center Description Basis/Code (2) Amount Cost Center Line #	Wkst. A-7 Ref.	
1.00 2.00 3.00 4.00	5. 00	
33. 01 MI SCELLANEOUS I NCOME B -400, 536 ADMI NI STRATI VE & GENERAL 5. 0	0 0	33. 01
33. 02 MISCELLANEOUS INCOME B -600, 424 OPERATION OF PLANT 7. 0	0 0	33. 02
33. 03 MISCELLANEOUS INCOME B -53, 915 LAUNDRY & LINEN SERVICE 8. 0	0 0	33. 03
33. 04 MI SCELLANEOUS I NCOME B -38, 000 HOUSEKEEPI NG 9. 0	0 0	33. 04
33. 05 MI SCELLANEOUS NCOME B -232, 518 DI ETARY 10. 0	0 0	33. 05
33.06 MISCELLANEOUS INCOME B -58,652 NURSING ADMINISTRATION 13.0	0	33. 06
33. 07 MI SCELLANEOUS NCOME B -77, 654 PHARMACY 15. 0	0 0	33. 07
33.08 MISCELLANEOUS INCOME B -20,020 ADULTS & PEDIATRICS 30.0	0 0	33. 08
33.09 MISCELLANEOUS INCOME B -42 OPERATING ROOM 50.0	0 0	33. 09
33. 10 MI SCELLANEOUS NCOME B -53, 067 RADI OLOGY-THERAPEUTI C 55. 0	0 0	33. 10
33. 11 MI SCELLANEOUS NCOME B -1, 200 RESPIRATORY THERAPY 65. 0	0 0	33. 11
33. 12 MI SCELLANEOUS I NCOME B -217, 000 PHYSI CAL THERAPY 66. 0	0 (0	33. 12
33. 13 MI SCELLANEOUS I NCOME B -26, 267 ELECTROENCEPHALOGRAPHY 70. 0	0 0	33. 13
33.14 MISCELLANEOUS INCOME B -204 CARDIAC REHABILITATION 76.9	7 0	33. 14
33.15 MISCELLANEOUS INCOME B -37,007 CLINIC 90.0	1	
33.16 MISCELLANEOUS INCOME B -145,553 WOUND CARE CENTER 90.0	1	
33. 17 MI SCELLANEOUS I NCOME B -1, 520 OP PSYCH CLINIC 90. 0	1	
33.18 MISCELLANEOUS INCOME B -259, 030 AMBULANCE SERVICES 95.0	ı	
33. 19 ACCRUED PTO A -105 NURSI NG ADMI NI STRATI ON 13. 0	l l	
33. 20 ACCRUED PTO A -838, 269 EMPLOYEE BENEFITS DEPARTMENT 4. C	l	000
33. 21 UNNECESSARY BORROWING A -750, 238 CAP REL COSTS-BLDG & FIXT 1. C	1	1
33. 22 BENEFIT EXPENSE A -18, 870, 009 EMPLOYEE BENEFITS DEPARTMENT 4. C	l l	
33. 23 CONTRI BUTI ON EXPENSE A -25, 000 ADMI NI STRATI VE & GENERAL 5. C	1	000
33. 24 PHYSICIAN RECRUITMENT A -91, 864 ADMINISTRATIVE & GENERAL 5. C 33. 25 PHYSICIAN RECRUITMENT A -1, 000 ADULTS & PEDIATRICS 30. C	1	
33. 25 PHYSI CI AN RECRUITMENT A -1,000 ADULTS & PEDI ATRI CS 30. 0 33. 26 PHYSI CI AN RECRUITMENT A -20, 461 OPERATI NG ROOM 50. 0	1	
33. 27 PHYSI CI AN RECRUITMENT A -1, 260 NURSI NG ADMI NI STRATI ON 13. 0	ı	1
33. 28 HAF FEES A -18, 062, 064 ADMI NI STRATI VE & GENERAL 5. 0	1	1
33. 29 CAFETERI A REVENUE B -1, 132, 008 CAFETERI A 11. 0		1
33. 30 WEGMILLER CAPITALIZED INTEREST A -343 CAP REL COSTS-BLDG & FIXT 1. C	1	1
33. 31 1983 CAPITALI ZED INTEREST A -3,968 CAP REL COSTS-BLDG & FIXT 1.0	1	1
33.32 OTHER CARRYFORWARD ADJUSTMENTS A 147,112 CAP REL COSTS-BLDG & FIXT 1.0	1	1
33. 33 START UP COSTS A -5, 243, 087 ADMI NI STRATI VE & GENERAL 5. C	1	
33.34 PENSION CASH CONTRIBUTION A 9,237,500 EMPLOYEE BENEFITS DEPARTMENT 4.0	1	1
ADJUSTMENT		
33.35 TELEPHONE A -941 ADULTS & PEDIATRICS 30.0	0 0	33. 35
33. 36 TELEPHONE A -2, 504 RADI OLOGY-DI AGNOSTI C 54. 0	0	33. 36
33. 37 TELEPHONE A -685 RADI OLOGY-THERAPEUTI C 55. 0	0 0	33. 37
33.38 MI SCELLANEOUS I NCOME B -42,045 PROMPTCARE 190.0	1 0	33. 38
33. 39 PHYSICIAN RECRUITMENT A -1, 810 PROMPTCARE 190. 0	1 0	33. 39
33.40 PHYSICIAN RECRUITMENT A -1,000 COMMUNITY HEALTH SERVICES 190.1	1	
33. 41 PENALTY TAX A -1, 724 OPERATION OF PLANT 7. 0		
33. 42 NONALLOWABLE MARKETING A -88, 250 ADMINISTRATIVE & GENERAL 5. C	•	
33. 43 NONALLOWABLE MARKETING A -795 PARAMED ED PRGM-PHARMACY 23. 0	0	33. 43
RESI DENCY	_	
33. 44 NONALLOWABLE MARKETING A -1, 867 OPERATING ROOM 50. C	1	
33. 45 NONALLOWABLE MARKETING A -50 PHYSICAL THERAPY 66. 0		
33. 46 NONALLOWABLE MARKETING A -47 AMBULANCE SERVICES 95. 0		
33.47 UNWONTED SITUATIONS A -3,342 ADMINISTRATIVE & GENERAL 5.0 TOTAL (sum of lines 1 thru 49) -32,066,890	9	33. 47 50. 00
(Transfer to Worksheet A,		30.00
column 6, line 200.)		

column 6, line 200.)

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0051 | Period: From 01/01/2018 To 12/31/2018 | Date/Time Prepared: 5/28/2019 12: 09 pm

				10 12/31/2010	5/28/2019 12:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			HO ALLOCATION	2, 444, 146	1, 159, 385	1. 00
2.00			HO ALLOCATION	5, 438, 811	0	2. 00
3.00	1		HO ALLOCATION	19, 953, 374	36, 129	3. 00
4.00			HO ALLOCATION	48, 145, 248		4. 00
4.01		NURSING ADMINISTRATION	HO ALLOCATION	0	999, 413	4. 01
4.03			SIP ER	7, 119, 266	1, 947, 838	4. 03
4.04			SHARED EMPLOYEES	341, 000	341, 000	4.04
4.05			SHARED EMPLOYEES	87, 718	87, 718	4. 05
4.06	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	5, 845, 975	5, 845, 975	4.06
4.07	35. 00	NEONATAL INTENSIVE CARE UNIT	SHARED EMPLOYEES	750, 050	750, 050	4. 07
4.08	50.00	OPERATING ROOM	SHARED EMPLOYEES	2, 152, 350	2, 152, 350	4. 08
4.09	51.00	RECOVERY ROOM	SHARED EMPLOYEES	1, 387	1, 387	4. 09
4. 10	55. 00	RADI OLOGY-THERAPEUTI C	SHARED EMPLOYEES	371, 825	371, 825	4. 10
4.11	57. 00	CT SCAN	SHARED EMPLOYEES	14, 583	14, 583	4. 11
4. 12	60.00	LABORATORY	SHARED EMPLOYEES	10, 640, 914	10, 640, 914	4. 12
4.13	66.00	PHYSI CAL THERAPY	SHARED EMPLOYEES	444, 682	444, 682	4. 13
4.14	70.00	ELECTROENCEPHALOGRAPHY	SHARED EMPLOYEES	1, 066, 667	1, 066, 667	4. 14
4. 15	90. 01	OP ONCOLOGY INFUSION CENTER	SHARED EMPLOYEES	107, 514	107, 514	4. 15
4. 16	90. 02	WOUND CARE CENTER	SHARED EMPLOYEES	277, 005	277, 005	4. 16
4. 17	90.05	OP PSYCH CLINIC	SHARED EMPLOYEES	53, 745	53, 745	4. 17
4. 18	95.00	AMBULANCE SERVICES	SHARED EMPLOYEES	128, 765	128, 765	4. 18
4. 19	190. 01	PROMPTCARE	SHARED EMPLOYEES	488, 765	488, 765	4. 19
4. 20	190. 09	CLINICAL TRIALS	SHARED EMPLOYEES	1, 900	1, 900	4. 20
4. 21	190. 11	COMMUNITY HEALTH SERVICES	SHARED EMPLOYEES	28, 205	28, 205	4. 21
5.00	0		0	105, 903, 895	75, 203, 151	5. 00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

 boon pooted to normaneer //	oor annie i aria, or 2, tho amoun	it air onabi o oii	our a bo riidi ou tou riii oor aiiir r	or time part.	
			Related Organization(s) and/or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	C		0.00	IU HEALTH SIP	0.00	6. 00
7.00	С		0.00	IU HEALTH PAOLI	0.00	7. 00
8.00	В	IU HEALTH	0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					I

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

011102	000.0				To 12/31/2018	Date/Time Pr 5/28/2019 12	repared: 2:09 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO						
1.00	1, 284, 761						1.00
2.00	5, 438, 811						2. 00
3.00	19, 917, 245						3. 00
4.00	-112, 088						4.00
4.01	-999, 413						4. 01
4.03	5, 171, 428	0					4. 03
4.04	0	0					4. 04
4.05	0	0					4. 05
4.06	0	0					4. 06
4.07	0	0					4. 07
4.08	0	0					4. 08
4.09	0	0					4. 09
4. 10	0	0					4. 10
4. 11	0	0					4. 11
4. 12	0	0					4. 12
4. 13	0	0					4. 13
4.14	0	0					4. 14
4. 15	0	0					4. 15
4. 16	0	0					4. 16
4. 17	0	0					4. 17
4. 18	0	0					4. 18
4. 19	0	0					4. 19
4.20	0	0					4. 20
4. 21	0	0					4. 21
5.00	30, 700, 744						5. 00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

nas no	been posted to worksheet A,	cordining 1 and/or 2, the amount arrowable should be marcated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	PHYSICIAN GROUP	6.00
	HOSPI TAL	7.00
8.00		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0051

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

Birst. A Line Cost Center/Pipps is an incent rine Total Remuneration Total Remunerati						'	12/31/2018	5/28/2019 12:	
1.00 3.00 3.00 5.00 6.00 5.00 6.00 5.00 5.00 6.00 7.00		Wkst. A Line #					RCE Amount	Physi ci an/Prov	·
1,00			l denti fi er	Remuneration	Component	Component			
1.00 5. CORDANIN STRATIVE A GREENAL 220 CO SORDANIN STRATIVE A GREENAL 230 CO SORDANIN STRATIVE A GREENAL 231 CO SORDANIN STRATIVE A GREENAL 231 CO SORDANIN STRATIVE A GREENAL 231 CO SORDANIN		1. 00	2.00	3.00	4. 00	5. 00	6. 00		
3.00	1. 00		ADMINISTRATIVE & GENERAL		253, 487	0		0	1. 00
4.00									
5.00 5.00									
6. DO						_			
7. 00						_			
9.00 10.00 1						o o			
10.00 5.00 ADM INSTRATIVE & CERERAL 1.696, 167 1.696, 167 0 246, 400 0 10.00 11.00 12.00 5.00 ADM INSTRATIVE & CERERAL 3, 300 3.300 0 211, 500 0 12.00 1	8.00	5. 00	ADMINISTRATIVE & GENERAL	78, 605	78, 605	0	211, 500	0	8. 00
11.00									
12.00									
13.00 23.00 PARAMED ED PROLITHMENACY 05.775 0.5775 0. 211,500 0. 13,00 13,00 15,00 15,00 30.00 0.00 0.00 0.15,00 15,00									
1.00 30 COMMUNIS & PEDIATRICS 433, 244 433, 244 63, 241 50 711, 500 50 15, 500 50 50 50 50 50 50 5						0			
15.00 3.00 CADULTS & PEDIATRICS 433, 246 0.0 211, 500 0.15, 501							,		
10. 00 30. DO/ADULIS & PEDIATRICS 144, 734 60, 876 83, 885 181, 300 1, 533 10, 00 17. 00 18. 00 32. DO/ADURANCY CARE UNIT 750, 050 476, 653 271, 597 237, 100 2, 697 18. 00 19									
17.00 32.00 CORROMARY CARE UNIT 24.000 24.000 0 211.500 0 17.00 19.00 41.00 SUBPROVIDER - IRR 209, 663 209, 663 271.397 237.100 2.97 18.00 19.00 41.00 SUBPROVIDER - IRR 209, 663 209, 663 209, 209 211.500 0 19.00 21.00 65.00 CORROMO - IRR 209, 663 209, 663 209, 209 211.500 0 209, 209 21.00 65.00 CORROMO - IRR 209, 663 209, 663 209, 209 211.500 0 209, 209 21.00 65.00 CORROMO - IRR 209, 209, 209 224, 432 22, 432 22, 432 239, 221.500 211.500 0 24.00 24.00 90.00 CORROMO CARE CENTER 59, 578 35, 690 59, 811 209, 209, 209, 209, 209, 209, 209, 209,					· ·	_			
18.00 35.00 EROMATAL INTERSIVE CARE UNIT 750,056 478,653 271,307 237,100 2,679 18.00 20.00 55.00 ADDITION CARE CHIEF 204,432 204,432 0 271,900 0 19.00 20.00									
19.00									
21.00									
22.00 69.00 ELECTROCARDIOLOGY 150.337 90.520 59.817 211.500 1,044 22.00 24.00 90.02 COUNDID CARE CENTER 193.130 193.130 0 211.500 479.23 00 25.00 90.05(DP PSYCH CLINIC 278.084 120.047 158.037 181.300 154 25.00 26.00 90.05(DP PSYCH CLINIC 278.084 120.047 158.037 181.300 154 25.00 27.00 90.05(DP PSYCH CLINIC 278.084 120.047 158.037 181.300 3.209 26.00 27.00 90.05(DP PSYCH CLINIC 278.084 120.047 158.037 181.300 3.209 26.00 27.00 90.05(DP PSYCH CLINIC 278.084 20.702 279 27.00 90.05(DP PSYCH CLINIC 278.084 20.702 279 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.0	20. 00			264, 432		0	271, 900	0	20.00
23.00 90.02 MOUND CARE CENTER 56,578 35,980 20,598 211,500 479 23.00						0			
24.00 90.0					· ·				
25.00 90.050P PSYCH CLINIC 567.200 546.768 20.432 181,300 3.50 2.50 20.200 27.00 91.00 MERGENCY 6.796.113 27.607.513 27.507.279 447.272 271,500 0.0 27.00 27.00									
27. 00						_			
20.00 West. A Line # Cost Center/Physician Identifier Unadjusted REE Septement of Un	26. 00	90. 05	OP PSYCH CLINIC						
Wist. A Line # Cost Center/Physician Identifier Sharper Cost of Limit Cost of Limi		91. 00	EMERGENCY			0	211, 500		
	200.00						5 11	10, 505	200. 00
1.00		Wkst. A Line #	,						
1.00			rdentrirei	Li iiii t					
1. 00									
2. 00	1 00			8.00					1 00
3. 00				0		-	_		
1.00				0	0	-) 		
5.00				Ö	0	_	Ö		
7. 00				0	0	0	0	0	
8.00				0	0		0		
9.00 5.00 ADMINISTRATIVE & GENERAL 150,674 7,534 0 0 0 9.00 10.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 0 11.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 12.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 13.00 23.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 13.00 23.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 14.00 30.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 15.00 30.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 16.00 30.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 16.00 30.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 17.00 32.00 CORONARY CARE UNIT 0 0 0 0 0 18.00 35.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 19.00 41.00 SUBPROVIDER - IRFE 0 0 0 0 0 19.00 45.00 AEMINISTRATIVE & GENERAL 0 0 0 0 22.00 65.00 AEMINISTRATIVE & GENERAL 0 0 0 0 23.00 90.02 WOUND CARE CENTER 48,706 2,435 0 0 0 22.00 24.00 90.02 WOUND CARE CENTER 0 0 0 0 0 25.00 90.05 P PSYCH CLINIC 279,707 13,985 0 0 0 22.00 25.00 91.00 EMERGENCY 1,055,846 52,792 0 0 0 22.00 20.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 253,487 1.00 20.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 253,487 1.00 20.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 52,10,576 3.00 3.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 0 4.00 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 5.00 ADMINISTRATIVE & GENERAL 0 0 0 0				0	0	_	0	1	
10.00				150 674	-		0		
11.00				130, 074	7, 334		0		
13.00				0	0	0	0	0	
14. 00	12.00			0	0	-	0	-	
14. 00 30. 00 ADULTS & PEDI ATRI CS 16, 125 806 0 0 0 0 14. 00	13. 00	23. 00		0	0	0	0	0	13. 00
15.00	14 00	30.00		16 125	806	0	0	0	14 00
16. 00				0 10, 123	000		Ö		
18. 00				133, 622	6, 681	0	0	0	
19. 00				0	0		0		
20. 00				307, 432	15, 372		0		
21. 00 65. 00 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 21. 00 22. 00 22. 00 69. 00 ELECTROCARDI OLOGY 106, 157 5, 308 0 0 0 0 22. 00 23. 00 90. 02 WOUND CARE CENTER 48, 706 2, 435 0 0 0 0 23. 00 24. 00 90. 02 WOUND CARE CENTER 0 0 0 0 0 0 24. 00 25. 00 90. 05 OP PSYCH CLI NI C 13, 423 671 0 0 0 26. 00 26. 00 90. 05 OP PSYCH CLI NI C 279, 707 13, 985 0 0 0 26. 00 27. 00 91. 00 EMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0		0		
22.00				٥	0		Ö		
24. 00				106, 157	5, 308	0	0	0	
25. 00	23. 00			48, 706	2, 435	0	0	0	23. 00
26. 00 90. 05 OP PSYCH CLINIC 279, 707 13, 985 0 0 0 0 26. 00 27. 00 200. 00 1, 055, 846 52, 792 0 0 0 0 200. 00 0 200. 00 0 200. 00 0 0 200. 00 0 0 0				0	0	0	0		
27. 00 91. 00 EMERGENCY 0 0 0 0 0 0 0 27. 00						0	0		
200.00				2/9, /0/	13, 985	0	0		
Wkst. A Line # Cost Center/Physician Provider Component Share of col. 14		71.00	EMERGENCI	1, 055, 846	52. 792	0	0		
Share of col. 14		Wkst. A Line #	Cost Center/Physician			RCE	Adjustment		
14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 2.53,487 1.00 2.00 5.00 ADMI NI STRATI VE & GENERAL 0 0 0 0 785,633 2.00 3.00 5.00 ADMI NI STRATI VE & GENERAL 0 0 0 5,210,576 3.00 4.00 5.00 ADMI NI STRATI VE & GENERAL 0 0 0 0 -42,351 4.00						Di sal I owance			
1. 00 2. 00 15. 00 16. 00 17. 00 18. 00 1. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 253, 487 1. 00 2. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 785, 633 2. 00 3. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 5, 210, 576 3. 00 4. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 -42, 351 4. 00									
1. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 253, 487 1. 00 2. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 785, 633 2. 00 3. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 5, 210, 576 3. 00 4. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 -42, 351 4. 00		1 00	2 00		16.00	17 00	18 00		
2. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 785, 633 2. 00 3. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 5, 210, 576 3. 00 4. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 -42, 351 4. 00	1. 00			0					1. 00
4.00 5.00 ADMINISTRATIVE & GENERAL 0 0 -42,351 4.00	2.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0		1	
				0					
3. 00 3. 00 ADWINI 3 TRATI VE α GENERAL 0 0 0 1, /31, 803 5. 00								1	
	5.00	J 5. 00	MUNITALI VE & GENERAL	ı	1 0	1 0	1,737,603	I	5.00

						10 12/31/2010	5/28/2019 12:	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
6.00		ADMINISTRATIVE & GENERAL	0	(0	293, 928		6. 00
7. 00		ADMINISTRATIVE & GENERAL	0	(0	683, 000		7. 00
8.00		ADMINISTRATIVE & GENERAL	0	(0	78, 605		8. 00
9.00		ADMINISTRATIVE & GENERAL	0	150, 67	157, 894			9. 00
10.00		ADMINISTRATIVE & GENERAL	0	(0	1, 696, 167		10. 00
11. 00		ADMINISTRATIVE & GENERAL	0	(0	10, 168		11. 00
12.00		ADMINISTRATIVE & GENERAL	0	(0	3, 300		12. 00
13.00		PARAMED ED PRGM-PHARMACY	0	(0	65, 775		13. 00
		RESI DENCY						
14.00		ADULTS & PEDIATRICS	0	16, 12!	8, 440			14. 00
15. 00	30. 00	ADULTS & PEDIATRICS	0	(0	433, 246		15. 00
16.00	30.00	ADULTS & PEDIATRICS	0	133, 622	2 0	60, 876		16. 00
17.00	32. 00	CORONARY CARE UNIT	0	(0	24, 000		17. 00
18.00	35. 00	NEONATAL INTENSIVE CARE UNIT	0	307, 432	2 0	478, 653		18. 00
19.00	41. 00	SUBPROVIDER - IRF	0	(0	209, 663		19. 00
20.00	55. 00	RADI OLOGY-THERAPEUTI C	0	(0	264, 432		20. 00
21.00	65. 00	RESPI RATORY THERAPY	0	(0	-2, 429		21. 00
22.00	69. 00	ELECTROCARDI OLOGY	0	106, 15	7 C	90, 520		22. 00
23.00	90. 02	WOUND CARE CENTER	0	48, 700	5 C	35, 980		23. 00
24.00	90. 02	WOUND CARE CENTER	0	(0	193, 130		24. 00
25.00	90. 05	OP PSYCH CLINIC	0	13, 423	7, 009	553, 777		25. 00
26.00	90. 05	OP PSYCH CLINIC	0	279, 70	7	120, 047		26. 00
27.00	91.00	EMERGENCY	0	(o o	6, 796, 113		27. 00
200.00			0	1, 055, 846	173, 343	20, 893, 622		200. 00

In Lieu of Form CMS-2552-10
Worksheet B
Part I
Bate/Time Prepared:
5/28/2019 12: 09 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051 Peri od: From 01/01/2018 To 12/31/2018 CAPITAL RELATED COSTS

			CAPITAL RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	DEDO & TIXI	WVDLL LQ011	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVI CE COST CENTERS						4 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	5, 805, 572					1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 750, 476 31, 670, 621	36, 651	11, 750, 476 74, 182	31, 781, 454		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	47, 982, 963			1, 913, 149	53, 271, 036	5. 00
7.00	00700 OPERATION OF PLANT	11, 751, 062	690, 940	1, 398, 463	643, 218	14, 483, 683	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	127, 102			0	157, 299	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 933, 199 1, 498, 368	l		545, 516 327, 295	3, 544, 076 1, 978, 708	9. 00 10. 00
11. 00	01100 CAFETERI A	798, 155			319, 842	1, 230, 780	
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 272, 435			1, 856, 006	8, 413, 163	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	11, 238, 131	33, 682		0	11, 339, 986	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	5, 516, 247 179, 640			1, 386, 933	6, 986, 854 242, 902	15. 00 16. 00
18. 00	01850 SOCIAL SERVICES	0	0		o	242, 702	18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	584, 938			152, 085	795, 317	18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	260, 339	5, 963	12, 069	87, 816	366, 187	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	29, 968, 197	724, 269	1, 465, 921	6, 297, 806	38, 456, 193	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	3, 531, 587	l		859, 232	4, 583, 433	
32.00	03200 CORONARY CARE UNIT	2, 541, 581	83, 456	168, 915	703, 286	3, 497, 238	32.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 320, 142			572, 932	3, 021, 002	35. 00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	873, 971	75, 379 0		283, 240	1, 385, 158 0	41. 00 42. 00
43. 00	04300 NURSERY	728, 762		_	201, 394	997, 935	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	8, 771, 436	1		1, 604, 453	11, 296, 504	50.00
50. 01 51. 00	O5001 CV SURGERY O5100 RECOVERY ROOM	3, 240, 859	0 21, 478	_	0 904, 208	0 4, 210, 016	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 440, 299	l		851, 486	4, 919, 412	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 535, 269	l		954, 385	4, 872, 746	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	3, 427, 039	136, 143		736, 590 0	4, 575, 325 0	55. 00 56. 00
57. 00	05700 CT SCAN	797, 389	-	_	204, 305	1, 025, 968	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	426, 062	l		118, 238	580, 682	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 398, 409	l		382, 213	1, 902, 047	59. 00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	11, 614, 257	108, 312 0		0	11, 941, 792 0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 449, 558			682, 229	3, 156, 529	65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 374, 054	l		1, 993, 284	9, 549, 737	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 868, 775	0 15, 205		0 2/1 022	0 1, 176, 587	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	1, 268, 389			261, 833 54, 852	1, 176, 387	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 499, 925		_	0	9, 499, 925	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 920, 065	l e	0	0	16, 920, 065	
73.00	07300 DRUGS CHARGED TO PATIENTS 07302 OP PHARMACY	20, 763, 918	0	0	0	20, 763, 918	
73. 01 74. 00	07400 RENAL DI ALYSI S	1, 254, 065	4, 884	9, 886	12	0 1, 268, 847	73. 01 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		o	0	75. 01
76. 97	07697 CARDI AC REHABILITATION	680, 373	23, 300	47, 159	186, 337	937, 169	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1, 247, 413	69, 001	139, 658	367, 966	1, 824, 038	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	2, 908, 227	20, 926		458, 999	3, 430, 506	90. 01
90. 02	09002 WOUND CARE CENTER	514, 480	28, 947	58, 588	176, 300	778, 315	90. 02
90. 03	09003 PAIN CLINIC	259, 187			61, 881	377, 300	90. 03
90. 05 91. 00	09005 OP PSYCH CLINIC 09100 EMERGENCY	1, 558, 406 6, 310, 038	l		581, 884 1, 432, 979	2, 365, 219 8, 239, 323	90. 05 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 575, 536	157, 122	332, 134	1, 102, 717	0, 237, 323	
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		1 524 022	7 740 211	94.00
95. 00 100. 00	09500 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM	5, 948, 098	87, 727 0	177, 558 0	1, 526, 928 0	7, 740, 311 0	95. 00 100. 00
	10100 HOME HEALTH AGENCY		Ö	0	o		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
114.00	NITHOU OILLI ZATTON KLYTEW-SINF	<u> </u>	l	I			114.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Net Expenses MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 C 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 294, 809, 478 4, 743, 562 9, 600, 965 29, 691, 112 289, 507, 615 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 845 11, 831 152, 454 190. 00 117 341 17 437 190. 01 19001 PROMPTCARE 39, 893 2, 557, 087 190. 01 2,040,647 80, 744 395, 803 190. 02 19002 RENTAL PROPERTIES 16, 018 119, 363 241, 591 376, 972 190. 02 190. 03 19003 OLCOTT 603, 009 190. 03 436, 634 17,046 34, 501 114, 828 190. 04 19004 PHYSI CI AN RECRUITMENT 0 190, 04 190. 05 19005 FOUNDATION 703 7,438 15,055 0 23, 196 190. 05 190. 06 19006 MARKETI NG 0 0 190. 06 190. 07 19007 HME STORE 880 0 880 190. 07 C 190. 08 19008 UNUSED SPACE 1, 189, 781 190. 08 393, 446 796, 335 190. 09 19009 CLINICAL TRIALS 163, 845 3, 099 6, 273 43, 179 216, 396 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 6, 116, 815 190. 11 4, 731, 161 298, 687 939, 394 147, 573 191. 00 19100 RESEARCH C 0 191 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 1, 140, 928 194. 00

825, 687

0

0

0

1, 895, 260

305, 037, 654

46, 984

101, 190

135, 529

14, 876

29, 728

5, 805, 572

95.096

204, 808

274, 311

30, 110

60, 169

11, 750, 476

173, 161

406, 540

31, 781, 454

0

0

0

2, 607, 798 194. 01

409, 840 194. 03

44, 986 194. 04

89, 897 194. 05

305, 037, 654 202. 00

0 194. 02

0 200.00

0 201. 00

194.01 07951 IU HEALTH BEDFORD HOSPITAL

194. 02 07952 IU HEALTH MORGAN HOSPITAL

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

194. 03 07953 IU HEALTH SIP

194. 04 07954 HOME CARE

194. 05 07955 HOSPI CE

200.00

201.00

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 12: 09 pm

				''	0 12/31/2010	5/28/2019 12:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	1		T			
1.00	00100 CAP REL COSTS-BLDG & FIXT					I	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					I	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	F0 074 00/				I	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	53, 271, 036	47 540 074			I	5. 00
7.00	00700 OPERATION OF PLANT	3, 064, 588	17, 548, 271			I	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	33, 283	44, 229			I	8. 00
9.00	00900 HOUSEKEEPI NG	749, 887	95, 733		4, 389, 702		9. 00
10.00	01000 DI ETARY	418, 673	224, 164		6, 632		10.00
11. 00	01100 CAFETERIA	260, 420	165, 192		9, 948		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 780, 133	417, 030		0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 399, 416	149, 186		0	0	14.00
15.00	01500 PHARMACY	1, 478, 341	122, 556		0	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	51, 395	92, 658	0	16, 581	0	16.00
18.00	01850 SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01	01851 CENTRAL STERILIZATION	168, 280	85, 383		0	0	18. 01
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	77, 481	26, 411	0	0	0	23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 404 007	0 007 050		0.000 (05	0.100.011	
30.00	03000 ADULTS & PEDIATRICS	8, 136, 897	3, 207, 950			2, 128, 014	30.00
31.00	03100 I NTENSI VE CARE UNI T	969, 804	282, 120		149, 225	196, 071	31.00
32. 00	03200 CORONARY CARE UNIT	739, 977	369, 644		0	166, 381	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	639, 211	187, 375		0	0	35. 00
41. 00	04100 SUBPROVI DER – I RF	293, 084	333, 871		132, 644	137, 711	41. 00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	211, 152	99, 275	2, 647	75, 027	0	43. 00
	ANCILLARY SERVICE COST CENTERS			1		_	
50. 00	05000 OPERATING ROOM	2, 390, 216	1, 348, 416	19, 342	414, 514	0	50.00
50. 01	05001 CV SURGERY	0	0	0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	890, 793	95, 129		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 040, 893	919, 279	11, 937	247, 050	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 031, 019	561, 110		132, 644	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	968, 088	603, 005	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	217, 084	35, 553		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	122, 866	53, 289		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	402, 452	177, 849		0	0	59. 00
60.00	06000 LABORATORY	2, 526, 752	479, 736	68	58, 032	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	667, 887	36, 240	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 020, 619	267, 157	19	20, 726	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	248, 953	67, 345	0	132, 644	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	297, 152	118, 850	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 010, 080	0	0	99, 483	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 580, 100	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 393, 417	0	0	99, 483	0	73. 00
73. 01	07302 OP PHARMACY	o	0	0	0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	268, 474	21, 634	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	o	0	0	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0	0	0	0	75. 01
76. 97		198, 295	103, 201	3, 017	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	•				
90.00	09000 CLI NI C	385, 946	305, 621	0	0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	725, 857	92, 686	0	20, 726	0	90. 01
90. 02	09002 WOUND CARE CENTER	164, 683	128, 211		16, 581	0	90. 02
90. 03	09003 PAIN CLINIC	79, 833	82, 363		0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	500, 454	329, 451		0	0	90. 05
91. 00	09100 EMERGENCY	1, 743, 350	726, 934		638, 351	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 1, 10, 222	,		220, 221	1	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
	09500 AMBULANCE SERVICES	1, 637, 765	388, 560	1, 673	0	0	95. 00
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
	10100 HOME HEALTH AGENCY	l ő	0	ő	n		101.00
. 5 1 . 50	SPECIAL PURPOSE COST CENTERS	. 9					1 55
113 00	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF					I	114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)		0	n	Λ	0	115. 00
	11600 HOSPI CE		0	l o	n		116. 00
118. 00	1 I	49, 985, 050	12, 844, 396	234, 811	4, 368, 976		
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , ,	, 5 . 1, 5 / 0		., 555, 776	_, 520, 177	1 3. 30
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32, 258	25, 889	0	0	Ο	190. 00
. , 5. 50	and the state of t	32, 230	20,007		<u> </u>		,

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 12: 09 pm

					5/28/2019 12:09 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5.00	7. 00	8. 00	9. 00	10.00
190. 01 19001 PROMPTCARE	541, 051	176, 696	0	0	0 190. 01
190. 02 19002 RENTAL PROPERTIES	79, 763	528, 687	0	0	0 190. 02
190. 03 19003 OLCOTT	127, 590	75, 499	0	0	0 190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	4, 908	32, 945	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190.07 19007 HME STORE	186	0	0	20, 726	0 190. 07
190. 08 19008 UNUSED SPACE	251, 745	1, 742, 659	0	0	0 190. 08
190. 09 19009 CLINICAL TRIALS	45, 787	13, 727	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	1, 294, 251	653, 631	0	0	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	241, 408	208, 103	0	0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	551, 781	448, 191	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	86, 718	600, 287	0	0	0 194. 03
194. 04 07954 HOME CARE	9, 519	65, 890	0	0	0 194. 04
194. 05 07955 HOSPI CE	19, 021	131, 671	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	O	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	53, 271, 036	17, 548, 271	234, 811	4, 389, 702	2, 628, 177 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 12: 09 pm

				12/31/2010	5/28/2019 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	1, 666, 340					11. 00
13.00 01300 NURSING ADMINISTRATION	90, 403	10, 700, 772				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	13, 888, 588			14. 00
15. 00 01500 PHARMACY	61, 482	. 0	55, 328	8, 705, 015		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	16	0	403, 552	16. 00
18. 00 01850 SOCI AL SERVI CES	0	0	0	0	0	18. 00
18. 01 01851 CENTRAL STERI LI ZATI ON	14, 179		111, 514	0	0	18. 01
23. 00 O2301 PARAMED ED PRGM-PHARMACY RESIDENCY	4, 015	0	239	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	404, 296	1 ' ' 1	649, 726	80, 504	39, 854	1
31. 00 03100 INTENSIVE CARE UNIT	50, 749	1	156, 797	35, 558	5, 856	
32. 00 03200 CORONARY CARE UNIT	41, 678		82, 250	13, 524	4, 490	1
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	30, 393		65, 018	4, 495	4, 467	
41. 00 04100 SUBPROVI DER - RF	17, 378		21, 188	475	1, 553	
42. 00 04200 SUBPROVI DER	0	-1	0	0	0	42.00
43. 00 04300 NURSERY	11, 513	161, 032	20, 302	515	1, 178	43. 00
ANCILLARY SERVICE COST CENTERS	02.212	(01 017	1 710 410	24 714	F1 220	FO 00
50. 00 05000 OPERATI NG ROOM	83, 313		1, 718, 410	34, 714	51, 229	50.00
50. 01 05001 CV SURGERY 51. 00 05100 RECOVERY ROOM	40.214	-1	41 103	4 0/1	0 070	50. 01
	49, 214		41, 193	4, 861	8, 079	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	46, 690	1	138, 677	9, 671	10, 207	1
53. 00 05300 ANESTHESI OLOGY	1	1 "1	0 E0 E21	11 244	11 420	53. 00 54. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	54, 380 36, 629		58, 521 178, 307	11, 366 920	11, 638 25, 532	1
56. 00 05600 RADI 01 SOTOPE	30, 029	12, 330	176, 307	920	25, 532	56.00
57. 00 05700 CT SCAN	11, 117		53, 181	2, 764	6, 918	1
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	6, 118	1	4, 704	693	2, 286	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	20, 154	1	184, 059	5, 297	16, 409	
60. 00 06000 LABORATORY	65, 624		104, 037	3, 277	24, 910	
64. 00 06400 I NTRAVENOUS THERAPY	03, 024		0	Ö	24, 710	
65. 00 06500 RESPIRATORY THERAPY	34, 983	1 -1	175, 185	4, 805	3, 762	
66. 00 06600 PHYSI CAL THERAPY	90, 108	1	8, 161	1, 000	7, 558	
67. 00 06700 OCCUPATI ONAL THERAPY	70, 100	1	0, 101	ol	0	67.00
68. 00 06800 SPEECH PATHOLOGY			0	ol	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	15, 569	58, 943	13, 817	1, 558	5, 642	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 962		20, 891	0	3, 668	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1	3, 428, 086	ol	19, 520	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	6, 105, 678	o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	0	8, 403, 504	45, 490	73. 00
73. 01 07302 OP PHARMACY	0	o	0	o	0	73. 01
74.00 07400 RENAL DIALYSIS	2	29	5, 196	2, 627	1, 201	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	o	0	o	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	o o	0	o	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	10, 097	32, 615	2, 856	82	798	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	18, 079	109, 337	5, 761	804	722	90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	25, 399	319, 618	61, 547	9, 885	4, 520	90. 01
90. 02 09002 WOUND CARE CENTER	7, 561	97, 308	29, 064	17	1, 634	90. 02
90. 03 09003 PAIN CLINIC	3, 034	28, 803	6, 625	221	749	90. 03
90. 05 09005 OP PSYCH CLINIC	25, 232		369	0	643	
91. 00 09100 EMERGENCY	93, 443	1, 116, 773	381, 272	69, 165	50, 961	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				
94. 00 09400 HOME PROGRAM DIALYSIS	0	이	_ 0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	118, 381	1	75, 307	6, 802	11, 778	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	1	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				Т		1112 00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF]			_	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE			0	o o		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 545, 175	10, 529, 907	13, 859, 245	8, 704, 828		
30	1, 545, 175	10, 527, 707	15, 557, 245	5, 704, 020	+03, 332	1, 10, 00

					5/28/2019 12:09 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI ON	SERVICES &		RECORDS &
			SUPPLY		LI BRARY
	11. 00	13. 00	14. 00	15. 00	16. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 342	l .	39	0	0 190. 00
190. 01 19001 PROMPTCARE	21, 860	66, 661	25, 021	89	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	6, 135	18, 881	16	0	0 190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	147	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	24	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	2, 734	235	52	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNI TY HEALTH SERVI CES	63, 557	85, 088	4, 215	98	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	7, 318		0	0	0 194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	17, 048	0	0	0	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 IU HEALTH SIP	0	0	0	0	0 194. 03
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	1, 666, 340	10, 700, 772	13, 888, 588	8, 705, 015	403, 552 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

				Т	o 12/31/2018	Date/Time Pre 5/28/2019 12:	
		OTHER GENE	RAL SERVICE			5/28/2019 12.	09 pili
	Cost Center Description	SOCI AL SERVI CES		PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	CENEDAL SERVICE COST CENTERS	18. 00	18. 01	23. 00	24. 00	25. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 18. 00 18. 01	O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY O1850 SOCIAL SERVICES O1851 CENTRAL STERILIZATION		1, 176, 913	l .			1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 18. 00
23. 00	INPATIENT ROUTINE SERVICE COST CENTERS	() 0	474, 333			23. 00
30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	(((((0 0 0		7, 028, 626 5, 426, 928 4, 348, 204 2, 539, 110	0 0 0 0	30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
50 00	ANCILLARY SERVICE COST CENTERS		1 070 250	ıl c	10 117 024		50.00
50. 00 50. 01 51. 00 52. 00 54. 00 55. 00 57. 00 58. 00 69. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 01 74. 00 75. 01 76. 97	05001 CV SURGERY 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06400 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07302 OP PHARMACY 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABILI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0 0 0 73, 370 0 0 3, 273 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 5, 963, 038 7, 915, 506 0 6, 881, 436 6, 460, 144 0 1, 352, 585 770, 638 2, 918, 645 15, 096, 915 0 4, 079, 391 11, 964, 408 0 0 1, 721, 058 1, 851, 362 15, 057, 094 26, 636, 143 34, 180, 145 0 1, 568, 010 0 1, 288, 130	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 01 74. 00 75. 01 76. 97
90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00	09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER 09003 PAIN CLINIC 09005 OP PSYCH CLINIC 09100 EMERGENCY	()	0 0 0 3,000 273 0 0 818	C	2, 650, 308 4, 690, 744 1, 226, 374 579, 201 3, 327, 922 13, 099, 685	0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00
95. 00 100. 0 101. 0	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 0 10000 I&R SERVICES-NOT APPRVD PRGM 0 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	(0	C C C C C	9, 980, 577 0 0		94. 00 95. 00 100. 00 101. 00
	0 11300 INTEREST EXPENSE 0 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00

			To	12/31/2018	
	OTHER GENER	DAL SEDVICE			5/28/2019 12:09 pm
	OTHER GENER	TAL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
oost denter bescriptron	SERVI CES		PRGM-PHARMACY		Residents Cost
	02	0121112127111011	RESI DENCY		& Post
					Stepdown
					Adjustments
	18. 00	18. 01	23. 00	24.00	25. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	0	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 175, 367	474, 333	281, 173, 922	0 118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	212, 982	0 190. 00
190. 01 19001 PROMPTCARE	0	0	0	3, 388, 465	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	985, 422	0 190. 02
190. 03 19003 OLCOTT	0	0	0	831, 130	0 190. 03
190.04 19004 PHYSICIAN RECRUITMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	61, 196	
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190.07 19007 HME STORE	0	1, 273	0	23, 089	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	3, 184, 185	
190. 09 19009 CLINI CAL TRIALS	0	0	0	278, 931	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	273	0	8, 217, 928	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	1, 597, 757	
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	3, 624, 818	
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194.03 07953 IU HEALTH SIP	0	0	0	1, 096, 845	0 194. 03
194. 04 07954 HOME CARE	0	0	0	120, 395	
194. 05 07955 HOSPI CE	0	0	0	240, 589	
200.00 Cross Foot Adjustments			0	0	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 176, 913	474, 333	305, 037, 654	0 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

				5/28/2019 12:	
		Cost Center Description	Total		
	CENED	AL CEDVICE COST CENTERS	26. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1.00
2.00	1	CAP REL COSTS MVBLE EQUIP			2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
7.00	1	OPERATION OF PLANT			7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING			8. 00 9. 00
10.00	1	DIETARY			10.00
11. 00	1	CAFETERI A			11. 00
13.00	1	NURSING ADMINISTRATION			13. 00
14.00	1	CENTRAL SERVICES & SUPPLY			14. 00
15.00	1	PHARMACY			15. 00
16. 00 18. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICES			16. 00 18. 00
18. 00	1	CENTRAL STERILIZATION			18. 00
23. 00	1	PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
		IENT ROUTINE SERVICE COST CENTERS			
30.00	1	ADULTS & PEDIATRICS	59, 873, 185		30. 00
31.00	1	I NTENSI VE CARE UNI T	7, 028, 626		31.00
32. 00 35. 00		CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	5, 426, 928		32. 00 35. 00
41. 00	1	SUBPROVI DER - I RF	4, 348, 204 2, 539, 110		41. 00
42. 00	1	SUBPROVI DER	0		42. 00
43.00	1	NURSERY	1, 580, 576		43. 00
		LARY SERVICE COST CENTERS			
50.00		OPERATI NG ROOM	19, 117, 834		50.00
50. 01	1	CV SURGERY	0		50. 01
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	5, 963, 038 7, 915, 506		51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	7, 713, 300		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	6, 881, 436		54. 00
55.00	05500	RADI OLOGY-THERAPEUTI C	6, 460, 144		55. 00
56. 00	1	RADI OI SOTOPE	0		56. 00
57. 00	1	CT SCAN	1, 352, 585		57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	770, 638 2, 918, 645		58. 00 59. 00
60.00	1	LABORATORY	15, 096, 915		60.00
64. 00	1	INTRAVENOUS THERAPY	0		64. 00
65.00	06500	RESPI RATORY THERAPY	4, 079, 391		65. 00
66. 00		PHYSI CAL THERAPY	11, 964, 408		66. 00
67.00	1	OCCUPATIONAL THERAPY	0		67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	1, 721, 058		68. 00 69. 00
70.00	1	ELECTROENCEPHALOGRAPHY	1, 851, 362		70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 057, 094		71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	26, 636, 143		72. 00
		DRUGS CHARGED TO PATIENTS	34, 180, 145		73. 00
		OP PHARMACY	1 5/0 010		73. 01
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	1, 568, 010		74. 00 75. 00
75. 00		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		75. 00
		CARDIAC REHABILITATION	1, 288, 130		76. 97
		TIENT SERVICE COST CENTERS			
90.00		CLINIC	2, 650, 308		90.00
90. 01 90. 02		OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	4, 690, 744 1, 226, 374		90. 01 90. 02
90. 02		PAIN CLINIC	579, 201		90. 02
90. 05		OP PSYCH CLINIC	3, 327, 922		90. 05
91.00		EMERGENCY	13, 099, 685		91.00
92.00	_	OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
		REI MBURSABLE COST CENTERS			
		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	9, 980, 577		94. 00 95. 00
	1	I&R SERVICES-NOT APPRVD PRGM	9, 980, 577		100.00
		HOME HEALTH AGENCY	o		101. 00
250		AL PURPOSE COST CENTERS	<u> </u>]
		INTEREST EXPENSE			113. 00
		UTI LI ZATI ON REVI EW-SNF			114. 00
	1	AMBULATORY SURGICAL CENTER (D. P.)	0		115.00
116.00		HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	281, 173, 922		116. 00 118. 00
110.00		IMBURSABLE COST CENTERS	201, 173, 722		1, 10. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	212, 982		190. 00
190. 01	19001	PROMPTCARE	3, 388, 465		190. 01

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	u of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0051	Peri od:	Worksheet B

From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: 5/28/2019 12:09 pm Cost Center Description Total 26.00 190. 02 19002 RENTAL PROPERTIES 190. 03 19003 OLCOTT 190. 02 985, 422 831, 130 190. 03 190. 04 19004 PHYSICIAN RECRUITMENT 190. 04 190. 05 19005 FOUNDATION 190. 05 61, 196 190. 06 19006 MARKETI NG 190. 07 19007 HME STORE 190. 06 0 190. 07 23,089 190. 08 19008 UNUSED SPACE 3, 184, 185 190. 08 190. 09 19009 CLINI CAL TRI ALS 190. 09 278, 931 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 190. 11 19011 COMMUNITY HEALTH SERVICES 190. 10 8, 217, 928 190. 11 191. 00 19100 RESEARCH 191. 00 0 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 193. 00 19300 NONPALD WORKERS 193. 00 0 194.00 07950 IU HEALTH PAOLI HOSPITAL 1, 597, 757 194. 00 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 194. 02 07952 IU HEALTH MORGAN HOSPITAL 3, 624, 818 194. 01 194. 02 194. 03 07953 IU HEALTH SIP 1, 096, 845 194. 03 194.04 07954 HOME CARE 120, 395 194. 04 194. 05 07955 HOSPI CE 194. 05 240, 589 200.00 200.00 Cross Foot Adjustments 0 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 305, 037, 654 202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				Io	12/31/2018	Date/lime Pre 5/28/2019 12:	
			CAPI TAL REI	ATED COSTS		7 07 207 20 17 121	, p
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	- 1					
1. 00 2. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	36, 651	74, 182	110, 833	110, 833	1. 00 2. 00 4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	1, 116, 048 690, 940	1, 398, 463	3, 374, 924 2, 089, 403	6, 674 2, 244	5. 00 7. 00
8. 00 9. 00 10. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	0 0	9, 986 21, 614 50, 610	43, 747	30, 197 65, 361 153, 045	0 1, 903 1, 142	8. 00 9. 00 10. 00
11. 00	01100 CAFETERI A	O	37, 296	75, 487	112, 783	1, 116	11. 00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	94, 154 33, 682		284, 722 101, 855	6, 475 0	13. 00 14. 00
15. 00	01500 PHARMACY		27, 670		83, 674	4, 839	
16. 00	01600 MEDICAL RECORDS & LIBRARY	o	20, 920		63, 262	0	16. 00
18. 00	01850 SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01 23. 00	O1851 CENTRAL STERILIZATION O2301 PARAMED ED PRGM-PHARMACY RESIDENCY	0 0	19, 277 5, 963	39, 017 12, 069	58, 294 18, 032	531 306	18. 01 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	5, 703	12,009	18, 032	300	23.00
30. 00	03000 ADULTS & PEDIATRICS	0	724, 269	1, 465, 921	2, 190, 190	21, 928	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	63, 695		192, 614	2, 998	
32. 00 35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 0	83, 456 42, 304	168, 915 85, 624	252, 371	2, 454 1, 999	32. 00 35. 00
41. 00	04100 SUBPROVI DER – I RF		75, 379		127, 928 227, 947	988	
42. 00	04200 SUBPROVI DER	l o	0	0	0	0	42. 00
43. 00	04300 NURSERY	0	22, 414	45, 365	67, 779	703	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	304, 436	616, 179	920, 615	5, 597	50.00
50. 00	05000 OPERATING ROOM		304, 430	010, 179	920, 613	5, 597	50.00
51. 00	05100 RECOVERY ROOM	o	21, 478	43, 471	64, 949	3, 154	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	207, 549	420, 078	627, 627	2, 971	52. 00
53.00	05300 ANESTHESI OLOGY	0	127 704	0	202 002	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C		126, 684 136, 143	256, 408 275, 553	383, 092 411, 696	3, 330 2, 570	
56. 00	05600 RADI OI SOTOPE	l o	0	0	0	0	56. 00
57. 00	05700 CT SCAN	o	8, 027	16, 247	24, 274	713	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	12, 031	24, 351	36, 382	412	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY		40, 154 108, 312	81, 271 219, 223	121, 425 327, 535	1, 333 0	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY		00,312	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	o	8, 182	16, 560	24, 742	2, 380	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	60, 317	122, 082	182, 399	6, 954	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 0	0	0	0	0	67. 00 68. 00
69. 00	1		15, 205	30, 774	45, 979	913	
70. 00		o	26, 833	54, 310	81, 143	191	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	72. 00 73. 00
73. 01	07302 OP PHARMACY		0	Ö	o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	4, 884	9, 886	14, 770	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01 76. 97	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	0 0	23, 300	47, 159	70, 459	0 650	75. 01 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	١	25, 300	47, 137	70, 437	030	70.77
90.00	09000 CLI NI C	0	69, 001	139, 658	208, 659	1, 284	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	20, 926		63, 280	1, 601	1
90. 02 90. 03	O9002 WOUND CARE CENTER O9003 PAI N CLINIC	0	28, 947 18, 595	58, 588 37, 637	87, 535 56, 232	615 216	
90. 05	09005 OP PSYCH CLINIC		74, 381	150, 548	224, 929	2, 030	
91. 00	09100 EMERGENCY	o	164, 122		496, 306	4, 999	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		^		ما	0	94.00
	09500 AMBULANCE SERVICES		87, 727	177, 558	265, 285	5, 327	
	10000 I&R SERVICES-NOT APPRVD PRGM	l o	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	o	0	0	o	0	101. 00
112 0	SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE						113. 00
	0 11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	0	o	0	115. 00
		<u>'</u>		<u>'</u>			

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			To	12/31/2018	Date/Time Pre 5/28/2019 12:	
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
116. 00 11600 HOSPI CE	0	0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 743, 562	9, 600, 965	14, 344, 527	103, 540	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 845	11, 831	17, 676	61	190. 00
190. 01 19001 PROMPTCARE	0	39, 893	80, 744	120, 637	1, 381	190. 01
190. 02 19002 RENTAL PROPERTIES	0	119, 363	241, 591	360, 954		190. 02
190. 03 19003 0LC0TT	0	17, 046	34, 501	51, 547	401	190. 03
190.04 19004 PHYSICIAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	7, 438	15, 055	22, 493		190. 05
190. 06 19006 MARKETI NG	0	0	0	0		190. 06
190. 07 19007 HME STORE	0	0	0	0		190. 07
190. 08 19008 UNUSED SPACE	0	393, 446	796, 335	1, 189, 781		190. 08
190. 09 19009 CLINI CAL TRI ALS	0	3, 099	6, 273	9, 372		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	147, 573	298, 687	446, 260		190. 11
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	46, 984		142, 080		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	101, 190	204, 808	305, 998	· ·	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		194. 02
194.03 07953 IU HEALTH SIP	0	135, 529		409, 840		194. 03
194.04 07954 HOME CARE	0	14, 876		44, 986		194. 04
194. 05 07955 HOSPI CE	0	29, 728	60, 169	89, 897	0	194. 05
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	5, 805, 572	11, 750, 476	17, 556, 048	110, 833	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 12: 09 pm

				'	0 12/31/2010	5/28/2019 12:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8.00	9. 00	10. 00	
	NERAL SERVICE COST CENTERS			1			1 00
	1100 CAP REL COSTS-BLDG & FLXT 1200 CAP REL COSTS-MVBLE EQUIP					1	1. 00 2. 00
	1400 EMPLOYEE BENEFITS DEPARTMENT					i	4.00
	1400 EMPLOTEE BENEFITS DEPARTMENT 1500 ADMINISTRATIVE & GENERAL	3, 381, 598				i	5.00
	1700 OPERATION OF PLANT	194, 530	2, 286, 177			i	7.00
	1800 LAUNDRY & LINEN SERVICE	2, 113	2, 266, 177 5, 762	1		i	8.00
	1900 HOUSEKEEPI NG	47, 600	12, 472	l	127, 337	i	9.00
	000 DI ETARY	26, 576	29, 204	1		210, 159	10.00
	100 CAFETERI A	16, 531	21, 521		289	210, 139	11. 00
	300 NURSI NG ADMI NI STRATI ON	112, 997	54, 330	· · ·	207	0	13. 00
	400 CENTRAL SERVICES & SUPPLY	152, 307	19, 436	1	٥	0	14. 00
	500 PHARMACY	93, 840	15, 966	1	o o	0	15. 00
	600 MEDI CAL RECORDS & LI BRARY	3, 262	12, 071	1 ,	481	0	16. 00
	850 SOCIAL SERVICES	0,202	,	0	0	0	18. 00
	851 CENTRAL STERI LI ZATI ON	10, 682	11, 124	362	o	0	18. 01
	301 PARAMED ED PRGM-PHARMACY RESIDENCY	4, 918	3, 441	0		0	23. 00
	PATIENT ROUTINE SERVICE COST CENTERS	1, 7.0	3,		٥,		20.00
	000 ADULTS & PEDIATRICS	516, 629	417, 932	14, 552	60, 880	170, 164	30.00
	100 INTENSIVE CARE UNIT	61, 560	36, 754	1		15, 679	31.00
	200 CORONARY CARE UNIT	46, 971	48, 157	1		13, 304	32.00
1	060 NEONATAL INTENSIVE CARE UNIT	40, 575	24, 411	1	l .	0	35. 00
1	100 SUBPROVI DER - I RF	18, 604	43, 497	1		11, 012	41.00
	200 SUBPROVI DER	0	0	o	0	0	42. 00
	300 NURSERY	13, 403	12, 933	429	2, 176	0	43.00
	CILLARY SERVICE COST CENTERS		•		·		
50.00 05	000 OPERATING ROOM	151, 723	175, 671	3, 136	12, 024	0	50.00
50. 01 05	001 CV SURGERY	0	0	0	o	0	50. 01
51.00 05	100 RECOVERY ROOM	56, 545	12, 393	3, 252	o	0	51.00
52. 00 05	200 DELIVERY ROOM & LABOR ROOM	66, 073	119, 763	1, 935	7, 166	0	52. 00
53. 00 05	300 ANESTHESI OLOGY	o	0	0	o	0	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	65, 446	73, 101	2, 806	3, 848	0	54.00
55. 00 05	500 RADI OLOGY-THERAPEUTI C	61, 451	78, 559	0	o	0	55. 00
56. 00 05	6600 RADI OI SOTOPE	0	0	0	o	0	56. 00
57. 00 05	700 CT SCAN	13, 780	4, 632	0	o	0	57. 00
58. 00 05	800 MAGNETIC RESONANCE IMAGING (MRI)	7, 799	6, 942	0	0	0	58. 00
59.00 05	900 CARDI AC CATHETERI ZATI ON	25, 546	23, 170	724	o	0	59. 00
60.00 06	0000 LABORATORY	160, 390	62, 500	11	1, 683	0	60.00
64.00 06	400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06	500 RESPI RATORY THERAPY	42, 395	4, 721	0	0	0	65. 00
66.00 06	600 PHYSI CAL THERAPY	128, 263	34, 805	3	601	0	66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06	800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06	900 ELECTROCARDI OLOGY	15, 803	8, 774	0	3, 848	0	69. 00
	000 ELECTROENCEPHALOGRAPHY	18, 862	15, 484	0	0	0	70. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	127, 593	0	0	2, 886	0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	227, 253	0	0	0	0	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	278, 880	0	0	2, 886	0	73. 00
	302 OP PHARMACY	0	0	0	0	0	73. 01
	400 RENAL DIALYSIS	17, 042	2, 818	0	0	0	74. 00
	500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0		0	75. 01
	697 CARDI AC REHABI LI TATI ON	12, 587	13, 445	489	0	0	76. 97
	TPATIENT SERVICE COST CENTERS						
	000 CLI NI C	24, 499	39, 816	1	_	0	90. 00
	0001 OP ONCOLOGY INFUSION CENTER	46, 075	12, 075	1	601	0	90. 01
	0002 WOUND CARE CENTER	10, 454	16, 703		481	0	90. 02
	003 PAIN CLINIC	5, 068	10, 730	1	0	0	90. 03
	005 OP PSYCH CLINIC	31, 767	42, 921	1	0	0	90. 05
	100 EMERGENCY	110, 662	94, 704	6, 371	18, 517	0	91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	HER REIMBURSABLE COST CENTERS						
	400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	500 AMBULANCE SERVICES	103, 960	50, 621	271	0	0	95. 00
1	0000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	ECIAL PURPOSE COST CENTERS	1		1			l
	300 I NTEREST EXPENSE					ı	113. 00
	400 UTI LI ZATI ON REVI EW-SNF					ı	114. 00
	500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	9	0		115. 00
1	600 HOSPI CE	0	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 173, 014	1, 673, 359	38, 072	126, 736	210, 159	118.00
	NREI MBURSABLE COST CENTERS			1			
190.00 19	0000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 048	3, 373	0	0	0	190. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time Prepared: | 5/28/2019 | 12:09 pm

					5/28/2019 12:	09 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10.00	
190. 01 19001 PROMPTCARE	34, 344	23, 020	0	0	0	190. 01
190. 02 19002 RENTAL PROPERTI ES	5, 063	68, 877	0	0	0	190. 02
190. 03 19003 OLCOTT	8, 099	9, 836	0	0	0	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	312	4, 292	0	0	0	190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0	190. 06
190.07 19007 HME STORE	12	0	0	601	0	190. 07
190. 08 19008 UNUSED SPACE	15, 980	227, 032	0	0	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	2, 906	1, 788	0	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	82, 155	85, 155	0	0	0	190. 11
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	15, 324	27, 112	0	0	0	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	35, 025	58, 390	0	0	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0	194. 02
194.03 07953 IU HEALTH SIP	5, 505	78, 205	0	0	0	194. 03
194.04 07954 HOME CARE	604	8, 584	0	0	0	194. 04
194. 05 07955 HOSPI CE	1, 207	17, 154	0	0	0	194. 05
200.00 Cross Foot Adjustments					I	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 381, 598	2, 286, 177	38, 072	127, 337	210, 159	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm

			100	12/31/2018	5/28/2019 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	152, 240					11. 00
13.00 01300 NURSING ADMINISTRATION	8, 259	466, 790				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	273, 598			14. 00
15. 00 01500 PHARMACY	5, 617	0	1, 090	205, 100		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	79, 076	16. 00
18. 00 01850 SOCIAL SERVICES	0	0	0	0	0	18. 00
18. 01 O1851 CENTRAL STERILIZATION	1, 295	i i	2, 197	0	0	18. 01
23. 00 O2301 PARAMED ED PRGM-PHARMACY RESIDENCY	367	0	5	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	36, 936		12, 800	1, 897	7, 724	30.00
31. 00 03100 INTENSI VE CARE UNI T	4, 637	25, 722	3, 089	838	1, 135	31.00
32. 00 03200 CORONARY CARE UNIT	3, 808		1, 620	319	870	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2,777	17, 210	1, 281	106	866	35.00
41. 00 04100 SUBPROVI DER - I RF	1, 588	9, 229	417	11	301	41.00
42. 00 04200 SUBPROVI DER	1 053	7 025	0 400	0	0	42.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 052	7, 025	400	12	228	43. 00
50. 00 05000 OPERATING ROOM	7, 612	29, 742	33, 854	818	10, 794	50.00
50. 01 05001 CV SURGERY	0		0	010	0,774	50. 01
51. 00 05100 RECOVERY ROOM	4, 496	-	812	115	1, 566	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 266	21, 738	2, 732	228	1, 978	52.00
53. 00 05300 ANESTHESI OLOGY	1, 200	21,700	2, 702	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 968	5, 559	1, 153	268	2, 255	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 346		3, 513	22	4, 948	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	1, 016	o	1, 048	65	1, 341	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	559	o	93	16	443	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 841	8, 423	3, 626	125	3, 180	59. 00
60. 00 06000 LABORATORY	5, 996	o	0	o	4, 828	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	o	0	o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	3, 196	0	3, 451	113	729	65. 00
66. 00 06600 PHYSI CAL THERAPY	8, 232	14	161	0	1, 465	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 422	2, 571	272	37	1, 093	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	362	0	412	0	711	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	67, 535	0	3, 783	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	120, 269	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	197, 995	8, 816	
73. 01 07302 OP PHARMACY	0	0	0	0	0	73. 01
74. 00 07400 RENAL DIALYSIS	0		102	62	233	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	U	0	75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97 07697 CARDI AC REHABI LI TATI ON	0 922	1, 423	0 56	0	0 155	75. 01 76. 97
OUTPATIENT SERVICE COST CENTERS	722	1,423	30		155	70. 77
90. 00 09000 CLINIC	1, 652	4, 770	113	19	140	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	2, 321	13, 942	1, 213	233	876	90. 01
90. 02 09002 WOUND CARE CENTER	691	4, 245	573	0	317	90. 02
90. 03 09003 PAIN CLINIC	277	1, 256	131	5	145	•
90. 05 09005 OP PSYCH CLINIC	2, 305		7	ol	125	•
91. 00 09100 EMERGENCY	8, 537	48, 716	7, 511	1, 630	9, 876	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-,		, -	,	,	92.00
OTHER REIMBURSABLE COST CENTERS				•		
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	10, 816	0	1, 484	160	2, 283	95. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	이	0	0		115.00
116. 00 11600 HOSPI CE	0	450 001	070.000	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	141, 169	459, 336	273, 020	205, 096	79, 076	1118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/28/2019 12:09 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & LI BRARY **SUPPLY** 11. 00 13.00 15.00 16.00 14.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 214 190. 01 19001 PROMPTCARE 1, 997 2, 908 493 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 190. 01 0 190. 02 190. 02 19002 RENTAL PROPERTIES 0 190. 03 19003 OLCOTT 0 0 190. 03 561 824 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190. 04 190. 05 19005 FOUNDATION 0 0 190. 05 13 0 190. 06 19006 MARKETI NG 0 0 190, 06 0 0 190. 07 19007 HME STORE 0 0 190. 07 2 190. 08 19008 UNUSED SPACE 0 0 0 190. 08 190. 09 19009 CLINICAL TRIALS 10 0 190. 09 250 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 r 190. 11 19011 COMMUNITY HEALTH SERVICES 5,807 83 0 190. 11 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 0 0 193. 00 19300 NONPALD WORKERS 0 0 193. 00 0 0 194.00 07950 IU HEALTH PAOLI HOSPITAL 669 0 194. 00 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 0 194. 01 1,558 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 194. 02 0 0 194.03 07953 IU HEALTH SIP 0 194. 03 0 0 194. 04 07954 HOME CARE 0 0 0 0 0 194. 04 194. 05 07955 HOSPI CE 0 0 194. 05 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 466, 790 273, 598 79, 076 202. 00 152, 240 205, 100

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				1	o 12/31/2018	Date/lime Pre 5/28/2019 12:	
		OTHER GENE	RAL SERVICE			072072017 12.	O7 piii
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24. 00	25. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10. 00 11. 00 13. 00 14. 00 15. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01850 SOCI AL SERVI CES 01851 CENTRAL STERI LI ZATI ON	0000	l .				10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 18. 00
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	0					23. 00
30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	000000000000000000000000000000000000000	0 0 0 0		3, 651, 479 350, 872 393, 022 217, 431 318, 168 0	0 0 0 0	30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS					_	
50. 00 50. 01 51. 00	O5000 OPERATING ROOM O5001 CV SURGERY O5100 RECOVERY ROOM	0	0		1, 429, 068 0 175, 361	0 0	50. 00 50. 01 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			861, 744	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0			0 546, 061	0	53. 00 54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		569, 261	0	55. 00
56. 00 57. 00	05600		0		0 46, 869	0	56. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ō		52, 646	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	920		190, 313 562, 943		59. 00 60. 00
64.00	06400 I NTRAVENOUS THERAPY	0	ō		0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		81, 727 362, 897	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		ő		0	1	67. 00
68. 00		0	0		0 80, 712	1	
70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		176		117, 341	0	69. 00 70. 00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		201, 797		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				353, 394 488, 577	0	72. 00 73. 00
73. 01	07302 OP PHARMACY	0	ō		0	0	73. 01
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0		35, 028	0	74. 00 75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		Ö		o o	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		100, 188	0	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0		280, 952	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	-		142, 217	0	90. 01
	09002 WOUND CARE CENTER 09003 PAIN CLINIC	0	215 20		121, 829 74, 080		90. 02 90. 03
90. 05	09005 OP PSYCH CLINIC		0	1	308, 732	0	90.05
	09100 EMERGENCY	0	59		807, 888		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
	09500 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM	0	1		440, 207	0	
	10000 T&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	1	i	0		100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS		I	I		I	
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
	· · · · · · · · · · · · · · · · · · ·	1			<u> </u>		

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

OTHER GENERAL SERVICE SOCIAL SERVICE SOCIAL SERVICE SOCIAL SERVICES STERILIZATION PRAMED ED PRAMED					o 12/31/2018	
SOCIAL SERVICES STERILIZATION PARAMED ED PRGM-PHARMACY Residents Cost & Post Stepdown Adjustments Residents Cost & Post Residents Cost Residents Cost & Post Residents Cost & Post Residents Cost Re						5/28/2019 12:09 pm
SERVI CES STERI LI ZATI ON PRGM-PHARMCY RESI DENCY RESID		OTHER GENER	RAL SERVICE			
SERVI CES STERI LI ZATI ON PRGM-PHARMCY RESI DENCY RESID	Cook Cooker Docerieties	COCLAL	CENTRAL	DADAMED ED	Cl-+-+-1	1 0
RESI DENCY	cost center bescription					
18.00 18.01 23.00 24.00 25.00 115.00 115.00 116.00 115.00 116.00		SERVICES	STERTLIZATION			
18.00 18.01 23.00 24.00 25.00 115.00				REST DENCY		
18.00						
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		10 00	10 01	22.00	24.00	
116.00 11600 HOSPI CE 0 0 0 0 0 0 0 0 0 118.00	115 00 11500 AMPHI ATORY SURCICAL CENTER (D. D.)	16.00	16.01	23.00	24.00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 84,374 0 13,468,944 0 118.00		0	0		0	
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 184, 782 0 190. 01 190. 01 19001 PROMPTCARE 0 0 0 184, 782 0 190. 01 190. 02 190. 02 190. 02 190. 02 190. 02 190. 03 190. 03 190. 03 10.COTT 0 0 0 71, 268 0 190. 04 190. 04 190. 04 190. 04 190. 05 190. 05 190. 05 190. 05 190. 05 190. 05 190. 05 190. 06 190. 07 190.		0	04 274	_	12 440 044	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		J U	04, 3/4		13, 400, 944	0 118.00
190. 01 19001 PROMPTCARE			0		22 272	0 100 00
190. 02 19002 RENTAL PROPERTIES 0 0 0 434, 894 0 190. 02 190. 02 190. 03 19003 OLCOTT 0 0 0 71, 268 0 190. 03 190.03 190.03 190.03 190.04 19004 PHYSI CI AN RECRUITMENT 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 0 0 27, 110 0 190. 05 190. 06 190.06 190.06 190.06 190.06 190.06 190.06 190.06 190.07 190.07 HME STORE 0 91 706 0 190. 07 190. 08 190.08 190.08 190.08 190.09 OLI NI CAL TRI ALS 0 0 14, 478 0 190. 09 190. 09 190.09 CLI NI CAL TRI ALS 0 0 14, 478 0 190. 09 190. 10 190.10 190.10 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 190. 11 190.11 COMMUNI TY HEALTH SERVI CES 0 20 626, 471 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 193. 00 193.00 NONPAI D WORKERS 0 0 0 0 185, 789 0 194. 00 194. 00 195. 00 194.		0	0			
190. 03 19003 19003 19004 19004 19004 19004 19004 19004 19005 19005 19005 19005 19005 19005 19005 19005 19005 19005 19006 19006 19006 19006 19006 19007 19007 19007 19007 19007 19008 19008 19008 19008 19008 19009		0	0			
190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 0 0 190. 04 190. 04 190. 05 19005 FOUNDATI ON 0 0 0 0 0 190. 05 190.05 190.05 190.05 190.05 FOUNDATI ON 0 0 0 0 0 190. 05 190. 05 190. 05 190. 06 190. 06 190. 06 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 08 190. 08 190. 08 190. 08 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 00 0 0 0 0 0 190. 00 0 190. 10 190. 11 190. 11 190. 11 190. 11 190. 11 190. 11 190. 11 190. 00 190. 00 190. 00 0 0 0 0 190. 10 190. 0		0	0			
190. 05			0		71, 200	
190. 06 19006 MARKETING 0 0 0 190. 06 190. 06 190. 07 19007 HME STORE 0 0 91 706 0 190. 07 190. 07 19007 HME STORE 0 0 91 706 0 190. 07 190. 08 190.08 UNUSED SPACE 0 0 0 0 1, 432, 793 0 190. 08 190. 09 190.09 CLI NI CAL TRI ALS 0 0 0 0 14, 478 0 190. 09 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 190. 10 190. 11 19011 COMMUNI TY HEALTH SERVI CES 0 20 626, 471 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 00 193. 00 193. 00 NONPAI D WORKERS 0 0 0 0 193. 00 194. 01 194. 01 07951 IU HEALTH BEDFORD HOSPI TAL 0 0 0 194. 01 194. 02 194. 03 07953 IU HEALTH MORGAN HOSPI TAL 0 0 0 194. 02 194. 03 07953 IU HEALTH SIP 0 0 0 493, 550 0 194. 03 194. 04 07954 HOME CARE 0 0 0 194. 05 194. 05 07955 HOSPI CE 0 0 0 194. 05 200. 00 Cross Foot Adjustments			0		27 110	
190. 07 19007 HME STORE 0 91 706 0 190. 07 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 190. 09 190. 09 19009 CLINI CAL TRI ALS 0 0 0 190. 09 190.			0		27, 110	
190. 08 19008 UNUSED SPACE 0 0 0 1,432,793 0 190. 08 190. 09 19009 CLI NI CAL TRI ALS 0 0 0 0 190. 09 190. 09 19009 CLI NI CAL TRI ALS 0 190. 09 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 0 0 0 190. 10 190. 11 19011 COMMUNI TY HEALTH SERVI CES 0 20 626, 471 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 191. 00 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 0 194. 00 194. 00 194. 01 07951 IU HEALTH BEDFORD HOSPI TAL 0 0 0 194. 01 194. 02 07952 IU HEALTH BEDFORD HOSPI TAL 0 0 0 194. 02 07952 IU HEALTH MORGAN HOSPI TAL 0 0 0 493, 550 0 194. 02 194. 03 07953 IU HEALTH SI P 0 0 493, 550 0 194. 04 194. 05 07955 HOSPI CE 0 0 0 104. 05 07955 HOSPI CE 0 0 0 194. 05 07955 HOSPI CE 0 0 0 194. 05 07955 HOSPI CE 0 0 0 194. 05 07955 Cross Foot Adjustments			01		706	
190. 09 19009 CLINICAL TRIALS 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 190. 11 19011 COMMUNITY HEALTH SERVICES 0 20 626, 471 0 190. 11 191. 00 19100 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 193. 00 194. 00 07950 IU HEALTH PAOLI HOSPITAL 0 0 0 0 194. 00 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 0 0 194. 00 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 0 0 194. 00 194. 02 07953 IU HEALTH MORGAN HOSPITAL 0 0 0 0 194. 00 194. 02 07955 HU HEALTH MORGAN HOSPITAL 0 0 0 0 194. 00 194. 02 07955 HU HEALTH MORGAN HOSPITAL 0 0 0 0 194. 02 194. 03 07953 IU HEALTH SIP 0 0 0 493, 550 194. 04 07954 HOME CARE 10 0 0 57955 HOSPICE 0 0 0 27, 069 27, 069		0	71			
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC 190. 11 19011 COMMUNITY HEALTH SERVICES 0 20 626, 471 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 I U HEALTH PAOLI HOSPITAL 0 0 0 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPITAL 0 0 0 402, 389 0 194. 01 194. 03 07953 I U HEALTH SI P 0 0 0 493, 550 0 194. 03 194. 04 07954 HOME CARE 0 0 0 27, 069 27, 069 0 200. 00		0	0			
190. 11 19011 COMMUNITY HEALTH SERVICES 0 20 626, 471 0 190. 11 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 192. 00 19200 Physicians' Private Offices 0 0 0 0 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193. 00 194. 00 07950 IU HEALTH PAOLI HOSPITAL 0 0 0 185, 789 0 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 0 402, 389 0 194. 01 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 0 493, 550 0 194. 02 194. 03 07953 IU HEALTH SIP 0 0 493, 550 0 194. 03 194. 04 07954 HOME CARE 0 0 0 54, 174 0 194. 04 194. 05 07955 HOSPICE 0 0 0 27, 069 0 200. 00		0	0		14, 470	
191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 193. 00 193. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 01 194. 01 194. 02 194. 01 194. 01 194. 01 194. 02 194. 02 194. 03 194. 04 194. 03 194. 04 194. 05 194. 04 194. 05 194		0	20		626 471	
192. 00		0	20		020, 471	
193. 00 19300 NONPAI D WORKERS 0 0 0 193. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 01 194. 01 194. 01 194. 01 194. 02 194. 03 07952 I U HEALTH BEDFORD HOSPI TAL 0 0 0 402, 389 0 194. 01 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPI TAL 0 0 0 493, 550 0 194. 02 194. 04 07954 HOME CARE 0 0 0 54, 174 0 194. 04 194. 05 07955 HOSPI CE 0 0 0 198. 258 0 194. 05 200. 00 Cross Foot Adjustments 27, 069 27, 069 0 200. 00			0		0	
194. 00 07950 I U HEALTH PAOLI HOSPITAL 0 0 0 185, 789 0 194. 00 194. 01 07951 I U HEALTH BEDFORD HOSPITAL 0 0 0 402, 389 0 194. 01 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPITAL 0 0 0 0 194. 02 194. 03 07953 I U HEALTH SI P 0 0 493, 550 0 194. 03 194. 04 07954 HOME CARE 0 0 54, 174 0 194. 04 194. 05 07955 HOSPICE 0 0 0 108, 258 0 194. 05 200. 00 Cross Foot Adjustments 27, 069 27, 069 0 200. 00			0		0	
194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 402, 389 0 194. 01 194. 02 194. 03 194. 03 194. 04 194. 03 194. 04 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 06 194. 05 194. 06 194. 06 194. 07 194. 0			0		195 790	
194. 02 07952 I U HEALTH MORGAN HOSPITAL			0			
194. 03 07953 I U HEALTH SIP 0 0 493, 550 0 194. 03 194. 04 07954 HOME CARE 0 0 54, 174 0 194. 04 194. 05 07955 HOSPICE 0 0 108, 258 0 194. 05 200. 00 Cross Foot Adjustments 27, 069 27, 069 0 200. 00			0		402, 307	
194. 04 07954 HOME CARE 0 0 54, 174 0 194. 04 194. 05 07955 HOSPI CE 0 0 108, 258 0 194. 05 200. 00 Cross Foot Adjustments 27, 069 27, 069 0 200. 00			0		403 550	
194. 05 07955 HOSPICE 0 0 108, 258 0 194. 05 200. 00 Cross Foot Adjustments 27, 069 27, 069 0 200. 00			0		1	
200.00 Cross Foot Adjustments 27,069 27,069 0 200.00			0			
			0	27 060		
			0	27,007	27,009	
202.00 TOTAL (sum lines 118 through 201) 0 84,485 27,069 17,556,048 0 202.00			84 485	27 060	17 556 048	

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: 5/28/2019 12: 09 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

		5/28/2019 12: 09	
Cost Center Description	Total	0, 20, 20, 12, 0,	, p
	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP			2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL			5. 00
7. 00 00700 OPERATION OF PLANT			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11. 00
13. 00 01300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00 01500 PHARMACY			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY			16. 00
18. 00 01850 SOCIAL SERVICES			18. 00
18. 01 01851 CENTRAL STERI LI ZATI ON			18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 651, 479		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	350, 872		31. 00
32. 00 03200 CORONARY CARE UNIT	393, 022		32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	217, 431		35. 00
41. 00 04100 SUBPROVI DER - RF	318, 168		41. 00
42. 00 04200 SUBPROVI DER	0		42. 00
43. 00 04300 NURSERY	106, 140		43. 00
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 OPERATING ROOM	1, 429, 068		50. 00
50. 01 05001 CV SURGERY	0		50. 01
51.00 05100 RECOVERY ROOM	175, 361		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	861, 744		52. 00
53. 00 05300 ANESTHESI OLOGY	0	[53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	546, 061		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	569, 261		55. 00
56. 00 05600 RADI 0I SOTOPE	o	[56. 00
57.00 05700 CT SCAN	46, 869	5	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	52, 646	[58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	190, 313	5	59. 00
60. 00 06000 LABORATORY	562, 943		60. 00
64. 00 06400 I NTRAVENOUS THERAPY	0		64. 00
65. 00 06500 RESPIRATORY THERAPY	81, 727		65. 00
66. 00 06600 PHYSI CAL THERAPY	362, 897		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		67. 00
68.00 06800 SPEECH PATHOLOGY	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	80, 712		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	117, 341		70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	201, 797		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	353, 394		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	488, 577		73. 00
73. 01 07302 OP PHARMACY	100, 577		73. 01
74. 00 07400 RENAL DI ALYSI S	35, 028		74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	35, 028		75. 00
75. 00 07300 ASC (NON-DISTINCT FART) 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		75. 00 75. 01
76. 97 07697 CARDIAC REHABILITATION	100, 188		75. 01 76. 97
OUTPATIENT SERVICE COST CENTERS	100, 108		, 0. 71
90. 00 O9000 CLINIC	280, 952		90. 00
90. 00 09000 CETNIC 90. 01 09001 OP ONCOLOGY INFUSION CENTER	142, 217		90. 00 90. 01
			90. 01 90. 02
90. 02 09002 WOUND CARE CENTER 90. 03 09003 PALN CLINIC	121, 829		90. 02 90. 03
	74, 080		
90. 05 09005 OP PSYCH CLINIC	308, 732		90. 05
91. 00 09100 EMERGENCY	807, 888		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)			92. 00
OTHER REIMBURSABLE COST CENTERS			04.00
94. 00 09400 HOME PROGRAM DIALYSIS	0		94.00
95. 00 09500 AMBULANCE SERVICES	440, 207		95.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0		00.00
101. 00 10100 HOME HEALTH AGENCY	0	10	01. 00
SPECIAL PURPOSE COST CENTERS			
113. 00 11300 I NTEREST EXPENSE			13. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF			14. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		15. 00
116. 00 11600 HOSPI CE	0		16. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 468, 944	11	18. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 373		90. 00
190. 01 19001 PROMPTCARE	184, 782		90. 01

		5/28/2019 12:09 pm
Cost Center Description	Total	
	26.00	
190. 02 19002 RENTAL PROPERTI ES	434, 894	190. 02
190. 03 19003 OLCOTT	71, 268	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	o	190. 04
190. 05 19005 FOUNDATI ON	27, 110	190. 05
190. 06 19006 MARKETI NG	o	190. 06
190.07 19007 HME STORE	706	190. 07
190. 08 19008 UNUSED SPACE	1, 432, 793	190. 08
190. 09 19009 CLI NI CAL TRI ALS	14, 478	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	o	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	626, 471	190. 11
191. 00 19100 RESEARCH	o	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	192. 00
193. 00 19300 NONPALD WORKERS	o	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	185, 789	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	402, 389	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	o	194. 02
194.03 07953 IU HEALTH SIP	493, 550	194. 03
194.04 07954 HOME CARE	54, 174	194. 04
194. 05 07955 HOSPI CE	108, 258	194. 05
200.00 Cross Foot Adjustments	27, 069	200.00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	17, 556, 048	202. 00

IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SOUARE FEET) (SOUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 936 618 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 936, 618 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5, 913 5, 913 104, 696, 943 4.00 00500 ADMINISTRATIVE & GENERAL 6. 302. 436 5 00 180 053 180 053 -53, 271, 036 5 00 251, 766, 618 7.00 00700 OPERATION OF PLANT 111, 470 111, 470 2, 118, 936 14, 483, 683 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1,611 1, 611 157, 299 8.00 00900 HOUSEKEEPI NG 3, 487 3, 487 1, 797, 080 0 3, 544, 076 9.00 9.00 01000 DI ETARY 10.00 1, 078, 199 1, 978, 708 8.165 8, 165 0 10 00 11.00 01100 CAFETERI A 6,017 6,017 1, 053, 647 1, 230, 780 11.00 01300 NURSING ADMINISTRATION 15, 190 13.00 15, 190 6, 114, 193 0 8, 413, 163 13.00 01400 CENTRAL SERVICES & SUPPLY 5, 434 5, 434 11, 339, 986 14.00 14.00 4, 568, 937 15.00 01500 PHARMACY 4.464 4.464 6, 986, 854 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 375 3, 375 0 242, 902 16.00 C 01850 SOCIAL SERVICES 0 18.00 0 18.00 01851 CENTRAL STERILIZATION 0 795, 317 3, 110 501.011 18.01 18.01 3, 110 23.00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY 962 962 289, 290 0 366, 187 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 116, 847 116, 847 20, 746, 819 0 38, 456, 193 30.00 03100 INTENSIVE CARE UNIT 0 31.00 10.276 10.276 2, 830, 547 4, 583, 433 31.00 32.00 03200 CORONARY CARE UNIT 13, 464 13, 464 2, 316, 816 3, 497, 238 32.00 6,825 1, 887, 395 02060 NEONATAL INTENSIVE CARE UNIT 0 3, 021, 002 35.00 6,825 35.00 04100 SUBPROVIDER - IRF 0 41.00 933, 071 1, 385, 158 41.00 12.161 12, 161 42.00 04200 SUBPROVI DER o 42.00 C 0 04300 NURSERY 43.00 3,616 3,616 663, 448 997, 935 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 49, 115 49, 115 5, 285, 508 0 11, 296, 504 50.00 05001 CV SURGERY 0 50.01 Ω 50.01 05100 RECOVERY ROOM 3, 465 3, 465 2, 978, 709 0 4, 210, 016 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 33, 484 33, 484 2, 805, 030 0 4, 919, 412 52.00 05300 ANESTHESI OLOGY 53 00 Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 20.438 20, 438 3, 144, 005 4, 872, 746 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 21, 964 21, 964 2, 426, 528 0 4, 575, 325 55.00 05600 RADI OI SOTOPE 56.00 56.00 1, 295 05700 CT SCAN 1, 295 1, 025, 968 57.00 673,036 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,941 1, 941 389, 509 580, 682 58.00 59.00 05900 CARDIAC CATHETERIZATION 6,478 6, 478 1, 259, 114 0 0 0 1, 902, 047 59.00 06000 LABORATORY 17, 474 60 00 17, 474 0 11, 941, 792 60 00 06400 I NTRAVENOUS THERAPY 64.00 0 \cap Λ 64.00 65.00 06500 RESPIRATORY THERAPY 1, 320 1, 320 2, 247, 451 3, 156, 529 65.00 66.00 06600 PHYSI CAL THERAPY 9,731 9, 731 6, 566, 423 0 9, 549, 737 66.00 06700 OCCUPATIONAL THERAPY 67 00 67 00 0 C0 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 2, 453 2, 453 862, 549 1, 176, 587 69.00 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4.329 4, 329 180, 696 1, 404, 384 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 499, 925 71.00 0 C 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 16, 920, 065 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 20, 763, 918 73.00 0 07302 OP PHARMACY 73.01 0 C 0 73.01 0 07400 RENAL DIALYSIS 74.00 788 788 40 1, 268, 847 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75 01 0 0 75 01 07697 CARDIAC REHABILITATION 3, 759 3, 759 613, 846 937, 169 76.97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 11, 132 11, 132 1, 212, 181 1, 824, 038 90.00 09001 OP ONCOLOGY INFUSION CENTER 1, 512, 067 0 3, 430, 506 90.01 3.376 3.376 90.01 09002 WOUND CARE CENTER 90.02 4.670 4,670 580, 779 778, 315 90 02 90.03 09003 PAIN CLINIC 3,000 3,000 203, 854 0 377, 300 90.03 09005 OP PSYCH CLINIC 90.05 12,000 12,000 1, 916, 886 2, 365, 219 90.05 09100 EMERGENCY 26, 478 26, 478 4, 720, 627 ol 91.00 91.00 8, 239, 323 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 09500 AMBULANCE SERVICES 95.00 14, 153 14, 153 5, 030, 120 0 7, 740, 311 95.00 100.00 10000 I&R SERVICES-NOT APPRVD PRGM C 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

				rom 01/01/2018 o 12/31/2018	Date/Time Pre	
	CAPITAL REL	ATED COSTS			5/28/2019 12:	09 piii
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
	1. 00	2. 00	SALARI ES) 4. 00	5A	5. 00	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	1.00	2.00				115. 00
116. 00 11600 HOSPI CE	0	Ö	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 765, 283	_	97, 810, 783	-53, 271, 036	236, 236, 579	
NONREI MBURSABLE COST CENTERS	, ,		, , , , , , , , , , , , , , , , , , , ,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	943	943	57, 442	0	152, 454	190. 00
190. 01 19001 PROMPTCARE	6, 436	6, 436	1, 303, 883	0	2, 557, 087	190. 01
190. 02 19002 RENTAL PROPERTIES	19, 257	19, 257	0	0	376, 972	190. 02
190. 03 19003 OLCOTT	2, 750	2, 750	378, 274	0	603, 009	1
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0		0		190. 04
190. 05 19005 FOUNDATI ON	1, 200	1, 200	0	0	-	190. 05
190. 06 19006 MARKETI NG	0	0	0	0		190. 06
190. 07 19007 HME STORE	0	0	0	0		190. 07
190. 08 19008 UNUSED SPACE	63, 475			0	1, 189, 781	
190. 09 19009 CLINI CAL TRI ALS	500	500		0	216, 396	
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	22 000	0		0		190. 10
190. 11 19011 COMMUNI TY HEALTH SERVI CES	23, 808	23, 808	3, 094, 623	0	6, 116, 815	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		192.00
194. 00 07950 I U HEALTH PAOLI HOSPITAL	7, 580	7, 580	570, 440	0	1, 140, 928	
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	16, 325		·		2, 607, 798	
194. 02 07952 I U HEALTH MORGAN HOSPI TAL	0,020	10, 323	1,007,200	0		194. 02
194. 03 07953 I U HEALTH SI P	21, 865	21, 865	0	0	409, 840	
194. 04 07954 HOME CARE	2, 400			0	44, 986	
194. 05 07955 HOSPI CE	4, 796	4, 796	0	0	89, 897	194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	5, 805, 572	11, 750, 476	31, 781, 454		53, 271, 036	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part	6. 198442	12. 545644			0. 211589	
204.00 Cost to be allocated (per Wkst. B, Part II)			110, 833		3, 381, 598	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001059		0. 013431	205. 00
206.00 NAHE adjustment amount to be alloca	ted					206. 00
(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						l

	Fi nanci al		J HEALIH BLOOMI	NGTON HOSPITAL			u of Form CMS-:	
COST A	LLOCATION	- STATISTICAL BASIS		Provi der Co	F	eriod: rom 01/01/2018	Worksheet B-1	
					1	o 12/31/2018	Date/Time Pre 5/28/2019 12:	pared: 09 pm
	Cost	Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
			PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(PATIENT DAYS)	(MANHOURS)	
			(340/11/2 1221)	LAUNDRY)	JERVI JE			
	OENEDAL CE	TOWN OF AGOT OFFITEDS	7. 00	8. 00	9. 00	10.00	11. 00	
1. 00		RVICE COST CENTERS REL COSTS-BLDG & FIXT						1.00
2. 00		REL COSTS-MVBLE EQUIP						2. 00
4.00		OYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00		NISTRATIVE & GENERAL ATION OF PLANT	639, 182					5. 00 7. 00
8.00	00800 LAUN	DRY & LINEN SERVICE	1, 611	1, 391, 505				8. 00
9.00	00900 HOUS		3, 487			I I		9.00
10. 00 11. 00	01000 DI ET 01100 CAFE		8, 165 6, 017		16 24		3, 173, 677	10.00
13. 00		ING ADMINISTRATION	15, 190		o c	I I	172, 180	1
		RAL SERVICES & SUPPLY	5, 434		C	· · · · · · · · · · · · · · · · · · ·	0	
15. 00 16. 00	01500 PHAR	MACY CAL RECORDS & LIBRARY	4, 464 3, 375		C 40	l l	117, 097 0	1
	01850 S0CI	AL SERVICES	0	Ö	C	1	0	1
18. 01	1 1	RAL STERILIZATION	3, 110		C	1	27, 005	1
23. 00		MED ED PRGM-PHARMACY RESIDENCY ROUTI NE SERVI CE COST CENTERS	962	0	C	0	7, 647	23. 00
30. 00	03000 ADUL	TS & PEDIATRICS	116, 847		5, 063	43, 793	770, 012	30.00
31. 00		NSIVE CARE UNIT	10, 276				96, 655	
32. 00 35. 00		NARY CARE UNIT ATAL INTENSIVE CARE UNIT	13, 464 6, 825				79, 379 57, 885	
41. 00	04100 SUBP	ROVIDER - IRF	12, 161	26, 517	320	2, 834	33, 098	
42.00	04200 SUBP		0	0	0	1	0	
43. 00	04300 NURS	SERVI CE COST CENTERS	3, 616	15, 685	181	0	21, 928	43.00
50.00	05000 OPER	ATING ROOM	49, 115	114, 624	1, 000	0	158, 677	50.00
50. 01	05001 CV S 05100 REC0		0	110 073		1	02.722	
51. 00 52. 00		VERY ROOM VERY ROOM & LABOR ROOM	3, 465 33, 484			1	93, 732 88, 925	1
53. 00	05300 ANES	THESI OLOGY	0	0	C	0	0	53. 00
54.00		OLOGY TUEDADELITIC	20, 438		320	1	103, 572	1
55. 00 56. 00	05600 RADI	OLOGY-THERAPEUTI C OLSOTOPE	21, 964	0		1	69, 762 0	1
57. 00	05700 CT S		1, 295	Ō	C	0	21, 174	1
58. 00		ETIC RESONANCE IMAGING (MRI)	1, 941		C I C	l l	11, 652	1
59. 00 60. 00	06000 LAB0	I AC CATHETERI ZATI ON RATORY	6, 478 17, 474		140	1	38, 384 124, 987	1
64. 00	06400 I NTR	AVENOUS THERAPY	0	0	C	0	0	64. 00
65. 00 66. 00		I RATORY THERAPY I CAL THERAPY	1, 320 9, 731	0 114	50 50	I - I	66, 627 171, 617	
67. 00		PATIONAL THERAPY	9, 731	•	0	l l	171, 617	1
		CH PATHOLOGY	0	_		- 1	0	
69. 00 70. 00		TROCARDI OLOGY TROENCEPHALOGRAPHY	2, 453 4, 329		320	l l	29, 652 7, 546	
71. 00		CAL SUPPLIES CHARGED TO PATIENTS	4, 327		240	- 1	7, 340	1
	1 1	. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
73. 00 73. 01	07300 DRUG 07302 OP P	S CHARGED TO PATIENTS	0	0	240	1	0	73. 00
	07400 RENA		788	0		- 1	4	74. 00
		(NON-DISTINCT PART)	0	0	C	-	0	70.00
75. 01 76. 97		HIATRIC/PSYCHOLOGICAL SERVICES IAC REHABILITATION	0 3, 759	0 17, 878		l l	0 19, 230	
70. 77		SERVICE COST CENTERS	3,737	17,070		1 0	17, 230	70. 77
	09000 CLI N		11, 132		C	· ·	34, 433	1
90. 01 90. 02		NCOLOGY INFUSION CENTER D CARE CENTER	3, 376 4, 670		50 40	1	48, 375 14, 400	1
	09003 PAI N		3, 000		C	l .	5, 779	1
90. 05	1 1	SYCH CLINIC	12,000		0	0	48, 056	1
	09100 EMER	GENCY RVATION BEDS (NON-DISTINCT PART)	26, 478	232, 866	1, 540	0	177, 969	91.00
72.00		BURSABLE COST CENTERS				1		72.00
		PROGRAM DI ALYSI S	0	0	C	l l	0	
		LANCE SERVICES SERVICES-NOT APPRVD PRGM	14, 153	9, 913 0	C I	1	225, 467 0	100.00
		HEALTH AGENCY	0	Ö	C	1		101. 00
112 00		IRPOSE COST CENTERS						112 00
		REST EXPENSE IZATION REVIEW-SNF						113. 00 114. 00
115.00	11500 AMBU	LATORY SURGICAL CENTER (D. P.)	0	0	c	o		115. 00
116. 00 118. 00	11600 HOSP	ICE OTALS (SUM OF LINES 1 through 117)	0 467, 847	0 1, 391, 505	10, 540	0 54, 086	0 2, 942, 906	116.00
110.00	Jour	OTALS (SOM OF LINES I THEOUGH III)	1 407, 047	1,371,305	10, 540	1 54, UOD	۷, ۶۴۷, ۶۷۵	1110.00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (HOURS OF (PATIENT DAYS) (MANHOURS) SERVICE) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 11.00 9.00 10.00 8.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 943 4, 461 190. 00 0 6, 436 0 41, 634 190. 01 190. 01 19001 PROMPTCARE 0 0 190. 02 19002 RENTAL PROPERTIES 0 0 190. 02 19.257 190. 03 19003 OLCOTT 2,750 0 0 11, 685 190. 03 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 0 190. 04 0 0 190. 05 19005 FOUNDATI ON 0 280 190. 05 1, 200 0 0 190. 06 19006 MARKETI NG 0 0 190.06 190. 07 19007 HME STORE 0 50 0 0 0 0 0 0 0 46 190. 07 190. 08 19008 UNUSED SPACE 63, 475 0 0 190. 08 190. 09 19009 CLINI CAL TRI ALS 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINI C 5, 208 190. 09 0 0 500 0 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 23,808 121, 050 190. 11 0 0 191. 00 19100 RESEARCH 0 191. 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 0 13, 937 194. 00 7,580 0 32, 470 194. 01 194. 01 07951 I U HEALTH BEDFORD HOSPITAL 0 0 16, 325 0 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 194. 02 194. 03 07953 IU HEALTH SIP 21, 865 0 0 0 0 194. 03 194. 04 07954 HOME CARE 0 0 194. 04 2,400 0 0 194. 05 07955 HOSPI CE 0 0 194, 05 4, 796 0 C 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201. 00 202.00 234, 811 Cost to be allocated (per Wkst. B, 17 548 271 4. 389. 702 2. 628. 177 1, 666, 340 202. 00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0 168746 414.513881 48. 592556 0. 525050 203. 00 27 454263 204.00 Cost to be allocated (per Wkst. B, 2, 286, 177 38, 072 127, 337 210, 159 152, 240 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 3.576723 0.027360 12.024268 3.885645 0. 047970 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm OTHER GENERAL SERVI CE Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCI AL ADMI NI STRATI ON SERVICES & (COSTED RECORDS & **SERVICES** REQUIS.) (TIME SPENT) SUPPLY LI BRARY (DI RECT NURS. (COSTED (GROSS REQUISITIONS) CHARGES) HRS.) 15.00 18. 00 13.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 1, 457, 077 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 38, 488, 091 14.00 14.00 15.00 01500 PHARMACY 0 153, 325 21, 508, 910 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 45 1, 566, 624, 839 16.00 01850 SOCIAL SERVICES 18.00 0 18.00 01851 CENTRAL STERILIZATION 309.028 0 0 18.01 18.01 0 23.00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY 663 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 623, 818 1, 800, 523 198, 915 154, 474, 171 0 30.00 03100 INTENSIVE CARE UNIT 31.00 80.291 434.516 87.858 22. 696, 356 0 31.00 17, 404, 329 32.00 03200 CORONARY CARE UNIT 68, 735 227, 931 33, 416 0 32.00 02060 NEONATAL INTENSIVE CARE UNIT 53, 721 180, 178 11, 107 17, 315, 512 35.00 35.00 0 04100 SUBPROVI DER - I RF 41.00 28, 809 58, 715 1, 174 6, 019, 532 41.00 0 42.00 04200 SUBPROVI DER 0 42.00 C 04300 NURSERY 43.00 21, 927 56, 262 1, 273 4, 564, 000 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 92.840 4, 762, 065 85, 773 201, 032, 079 0 50.00 05001 CV SURGERY 50.01 0 50.01 05100 RECOVERY ROOM 87,649 12,011 31, 313, 685 51.00 51.00 114, 155 52.00 05200 DELIVERY ROOM & LABOR ROOM 67.854 384, 302 23, 896 39, 561, 676 0 52.00 05300 ANESTHESI OLOGY 53 00 Λ 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 17.352 162, 174 28, 085 45, 108, 582 0 54.00 05500 RADI OLOGY-THERAPEUTI C 98, 962, 524 55.00 9,850 494, 126 2, 273 0 55.00 05600 RADI OI SOTOPE 56.00 56.00 0 05700 CT SCAN 147, 375 26, 814, 322 57.00 0 6,830 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 13, 035 1,712 8, 859, 864 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 26, 293 510,066 13,089 63, 600, 103 0 59.00 06000 LABORATORY 96, 552, 046 60 00 0 0 60 00 06400 INTRAVENOUS THERAPY 64.00 0 \cap 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 485, 472 11, 872 14, 580, 246 0 65.00 66.00 06600 PHYSI CAL THERAPY 44 22, 615 29, 294, 610 0 66.00 0 06700 OCCUPATIONAL THERAPY 67 00 0 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 38, 289 3,850 21, 867, 766 69.00 69.00 8,026 0 70.00 07000 ELECTROENCEPHALOGRAPHY 57, 893 14, 217, 782 0 70.00 C 9, 499, 925 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71 00 0 75, 657, 223 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 16, 920, 065 117, 439, 983 0 72.00 07300 DRUGS CHARGED TO PATIENTS 20, 763, 918 176, 318, 541 73.00 73.00 07302 OP PHARMACY 0 73.01 0 73.01 \cap 07400 RENAL DIALYSIS 14, 399 74.00 4 6.491 4, 654, 015 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 C 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 75 01 C 0 07697 CARDIAC REHABILITATION 7, 914 3, 093, 904 0 76. 97 76.97 4.441 202 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 14,888 15, 965 1.987 2, 799, 119 0 09001 OP ONCOLOGY INFUSION CENTER 170, 559 17, 518, 614 90. 01 90.01 43.521 24, 425 0 09002 WOUND CARE CENTER 90.02 90.02 13, 250 80.541 42 6. 333, 926 0 90.03 09003 PAIN CLINIC 3, 922 18, 359 545 2, 902, 592 0 90.03 09005 OP PSYCH CLINIC 90.05 14,509 1,022 2, 493, 323 90.05 09100 EMERGENCY 152,066 1, 056, 582 170, 896 197, 521, 357 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 16, 807 0 95.00 95.00 208, 692 45, 653, 057 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 C 0 100, 00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE l113. 00

114.00

114.00 11400 UTILIZATION REVIEW-SNF

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm OTHER GENERAL SERVI CE MEDI CAL Cost Center Description NURSI NG CENTRAL **PHARMACY** SOCI AL ADMI NI STRATI ON (COSTED RECORDS & SERVI CES SERVICES & REQUIS.) LI BRARY (TIME SPENT) SUPPLY (DI RECT NURS. (COSTED (GROSS HRS.) REQUISITIONS) CHARGES) 13.00 14.00 15.00 16.00 18. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 0 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 433, 811 38, 406, 776 21, 508, 449 1, 566, 624, 839 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 107 C 190. 01 19001 PROMPTCARE 220 0 0 190. 01 9,077 69, 337 190. 02 19002 RENTAL PROPERTIES 0 0 0 190. 02 190. 03 19003 OLCOTT 0 0 190. 03 45 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.571 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190, 04 0 Ω 0 190. 05 190. 05 19005 FOUNDATI ON 0 0 0 190. 06 19006 MARKETI NG 0 0 0 0 190.06 190. 07 19007 HME STORE 0 0 0 190. 07 0 190.08 19008 UNUSED SPACE 0 0 190. 08 C 190. 09 19009 CLINICAL TRIALS 32 144 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 0 190. 11 11,586 11, 682 241 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 0 194.00|07950|IU HEALTH PAOLI HOSPITAL 0 194. 00 0 0 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 194. 01 0 0 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 194. 02 194. 03 07953 IU HEALTH SIP 0 194. 03 0 0 194. 04 07954 HOME CARE 0 0 0 194. 04 194. 05 07955 HOSPI CE 0 0 194. 05 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 13, 888, 588 10, 700, 772 8, 705, 015 403, 552 0 202. 00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 7. 343999 0.360854 0.404717 0.000258 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 205, 100 79,076 0 204. 00 466, 790 273, 598

0. 320361

0.007109

0.009536

0.000050

0.000000 205.00

206.00

207. 00

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

205.00

206.00

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051

					To 12/31/2018 Date/lime Pro 5/28/2019 12:	
			OTHER GENERAL			
			SERVI CE	DADAMED ED		
		Cost Center Description	CENTRAL STERI LI ZATI ON	PARAMED ED		
			(TIME SPENT)	RESI DENCY		
			((TIME SPENT)		
	OENED	AL CERVILOE COCT OFFITERS	18. 01	23. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	T		T	1.00
2.00	1	CAP REL COSTS-BEDG & TTXT				2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	1	ADMINISTRATIVE & GENERAL				5. 00
7.00	1	OPERATION OF PLANT				7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING				8. 00 9. 00
10. 00	1	DI ETARY				10.00
11. 00	1	CAFETERI A				11. 00
13. 00	1	NURSING ADMINISTRATION				13. 00
14.00	1	CENTRAL SERVICES & SUPPLY				14.00
15. 00 16. 00	1	PHARMACY MEDI CAL RECORDS & LI BRARY				15. 00 16. 00
18. 00		SOCIAL SERVICES				18. 00
18. 01		CENTRAL STERILIZATION	64, 725			18. 01
23. 00		PARAMED ED PRGM-PHARMACY RESIDENCY	0	100		23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS		0		30.00
31. 00		INTENSIVE CARE UNIT	0	0	i de la companya del companya de la companya de la companya del companya de la co	31.00
32. 00	1	CORONARY CARE UNIT	0	0	•	32.00
35. 00	1	NEONATAL INTENSIVE CARE UNIT	0	0		35. 00
41.00	1	SUBPROVIDER - IRF	0	0	l control of the cont	41.00
42. 00 43. 00		SUBPROVI DER NURSERY	0	0		42. 00 43. 00
43.00		LARY SERVICE COST CENTERS	0	0	/	43.00
50.00	05000	OPERATING ROOM	59, 360	0	l control of the cont	50.00
50. 01		CV SURGERY	0	0		50. 01
51. 00 52. 00	4	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	4, 035	0		51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	4,035	0		53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	180	0		54.00
55. 00		RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00	1	RADI OI SOTOPE	0	0	l e e e e e e e e e e e e e e e e e e e	56.00
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	0	l e e e e e e e e e e e e e e e e e e e	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	705	0	l control of the cont	59. 00
60.00	06000	LABORATORY	O	0		60.00
64.00	1	I NTRAVENOUS THERAPY	0	0	1	64. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	l e e e e e e e e e e e e e e e e e e e	65. 00 66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	0	l e e e e e e e e e e e e e e e e e e e	67. 00
68. 00		SPEECH PATHOLOGY	0	0		68. 00
	1	ELECTROCARDI OLOGY	0	0		69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	135	0		70. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	l e e e e e e e e e e e e e e e e e e e	71.00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	100	l e e e e e e e e e e e e e e e e e e e	73. 00
73. 01		OP PHARMACY	0	0	1	73. 01
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0		74. 00 75. 00
75. 00 75. 01		PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		75. 00
76. 97	1	CARDI AC REHABI LI TATI ON	O	0	l control of the cont	76. 97
		TIENT SERVICE COST CENTERS	,			
90. 00 90. 01		CLINIC	0	0	l e e e e e e e e e e e e e e e e e e e	90.00
90.01		OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	165	0		90. 01 90. 02
90. 03		PAIN CLINIC	15	0		90. 03
90. 05	09005	OP PSYCH CLINIC	0	0	l e e e e e e e e e e e e e e e e e e e	90. 05
91.00		EMERGENCY	45	0		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS				92. 00
94. 00		HOME PROGRAM DIALYSIS	O	0		94. 00
95. 00	09500	AMBULANCE SERVICES		0	l e e e e e e e e e e e e e e e e e e e	95. 00
	1	I &R SERVI CES-NOT APPRVD PRGM	0	0	i de la companya del companya de la companya de la companya del companya de la co	100.00
101.00		HOME HEALTH AGENCY] 0	0)	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE				113. 00
114.00	11400	UTILIZATION REVIEW-SNF				114. 00
115. 00	11500	AMBULATORY SURGICAL CENTER (D. P.)	o	0)	115. 00
		<u> </u>				

SERVICE SERVICE CENTRAL STERILIZATION (TI ME SPENT) TIME SPENT) TIME SPENT TIME
Cost Center Description CENTRAL STERILIZATION (TIME SPENT) RSIDENCY (TIME SPENT) 18.01 23.00 116.00 11600 HOSPI CE 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 64,640 100 118.00 NONREI MBURSABLE COST CENTERS
STERILIZATION (TIME SPENT) PRGM-PHARMACY RESIDENCY (TIME SPENT) 18.01 23.00 116.00
TIME SPENT RESIDENCY (TIME SPENT) RESID
116. 00 11600 HOSPI CE
18.01 23.00
116. 00 11600 HOSPI CE
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 64, 640 100 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 190. 01 190. 02 190. 02 19002 RENTAL PROPERTIES 0 0 190. 02 190. 03 190. 03 190. 04 190. 0
NONRE MBURSABLE COST CENTERS 190.00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 0 0 190.00 190.01 190.01 190.01 190.02 190.02 190.02 190.02 190.02 190.03 190.03 190.03 190.03 190.04 19
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 19001 PROMPTCARE 0 0 190. 02 19002 RENTAL PROPERTIES 0 0 190. 03 19003 OLCOTT 0 0 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0
190. 01 19001 PROMPTCARE 0 0 190. 01 190. 02 19002 RENTAL PROPERTI ES 0 0 190. 02 190. 03 19003 0LCOTT 0 0 190. 03 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 190. 04
190. 02 19002 RENTAL PROPERTI ES 0 0 190. 02 190. 03 19003 0LCOTT 0 0 190. 03 190. 04 19004 19004 19004 19004 19004
190. 03 19003 OLCOTT 0 0 190. 03 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 190. 04
190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 190. 04
190. 05 19005 FOUNDATI ON 0 190. 05
190. 05 19005 FOUNDATION 0 190. 05 190. 06 19006 MARKETING 0 0 190. 06
190. 06 19006 MARKETING 0 0 190. 06 190. 07 19
190. 07 190.07 HWE STORE 70 0 190. 07 190. 08
190. 06 19006 UNUSED SPACE 0 190. 06 190. 06 190. 09 190. 09 190. 09 190. 09 190. 09
190. 09 19009 CETNICAE TRIAES 0 0 190. 10 190. 10 190. 10 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES 15 0 190. 11
191. 00 19100 RESEARCH 0 0 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00
193. 00 19300 NONPAI D WORKERS 0 0 193.00
194. 00 07950 I U HEALTH PAOLI HOSPI TAL 0 0 0 194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL 0 0 1194. 01
194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 0 0 194. 02
194. 03 07953 I U HEALTH SIP 0 0 194. 03
194. 04 07954 HOME CARE 0 0 0 194. 04
194. 05 07955 HOSPI CE 0 0 0 194. 05
200.00 Cross Foot Adjustments 200.00
201.00 Negative Cost Centers 201.00
202.00 Cost to be allocated (per Wkst. B, 1,176,913 474,333 202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 18.183283 4,743.330000 203.00
203.00 Unit Cost multiplier (wkst. B, Part 1) 16.163263 4,743.330000 204.00 204.00 204.00 204.00 204.00 204.00
204.00 Cost to be affocated (per wkst. B, 84,465 27,009 204.00
205.00 Unit cost multiplier (Wkst. B, Part 1.305292 270.690000 205.00
[11] [11] [11] [11] [11] [11] [11] [11]
206.00 NAHE adjustment amount to be allocated 0
(per Wkst. B-2)
207.00 NÄHE unit cost multiplier (Wkst. D, 0.000000 207.00
Parts III and IV)

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 12:09 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 59, 873, 185 59, 873, 185 8.440 59, 881, 625 7, 028, 626 03100 INTENSIVE CARE UNIT 7, 028, 626 7, 028, 626 31.00 03200 CORONARY CARE UNIT o 32.00 5, 426, 928 5, 426, 928 5, 426, 928 02060 NEONATAL INTENSIVE CARE UNIT 4.348.204 4. 348. 204 4, 348, 204 35.00 0 35, 00 04100 SUBPROVIDER - IRF 41.00 2, 539, 110 2, 539, 110 0 2, 539, 110 41.00 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 1, 580, 576 1, 580, 576 1, 580, 576 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19, 117, 834 19, 117, 834 0 19, 117, 834 50.00 50.01 05001 CV SURGERY 0 50.01 0 51.00 05100 RECOVERY ROOM 5, 963, 038 5, 963, 038 5, 963, 038 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 915, 506 7, 915, 506 7, 915, 506 52.00 53.00 05300 ANESTHESI OLOGY 0 0 05400 RADI OLOGY-DI AGNOSTI C 6, 881, 436 6, 881, 436 54.00 0 6, 881, 436 05500 RADI OLOGY-THERAPEUTI C 55 00 6, 460, 144 6, 460, 144 6, 460, 144 55 00 56.00 05600 RADI OI SOTOPE Λ 56.00 57.00 05700 CT SCAN 1, 352, 585 1, 352, 585 1, 352, 585 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 770, 638 770, 638 770, 638 05900 CARDIAC CATHETERIZATION 2, 918, 645 2, 918, 645 2 918 645 59 00 59 00 0 60.00 06000 LABORATORY 15, 096, 915 15, 096, 915 15, 096, 915 06400 INTRAVENOUS THERAPY 64.00 0 0 65 00 06500 RESPIRATORY THERAPY 4.079.391 4.079.391 4, 079, 391 65 00 06600 PHYSI CAL THERAPY 66.00 11, 964, 408 11, 964, 408 11, 964, 408 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 06900 ELECTROCARDI OLOGY 69 00 1, 721, 058 1, 721, 058 1, 721, 058 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 1, 851, 362 1, 851, 362 1, 851, 362 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 057, 094 15, 057, 094 15, 057, 094 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26, 636, 143 26, 636, 143 26, 636, 143 73.00 07300 DRUGS CHARGED TO PATIENTS 34, 180, 145 34, 180, 145 34, 180, 145 73 00 73.01 07302 OP PHARMACY 0 Ω 73.01 07400 RENAL DIALYSIS 0 74.00 1, 568, 010 1, 568, 010 1, 568, 010 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0

281, 173, 922

281, 173, 922

281, 189, 371 202. 00

15. 449

202.00

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051

						5/28/2019 12:	09 pm
				: XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS	1 400 (50 (04)		100 (50 (0)	1		
	3000 ADULTS & PEDIATRICS	123, 652, 604		123, 652, 604			30.00
	100 INTENSIVE CARE UNIT	22, 696, 356		22, 696, 356			31. 00
	2200 CORONARY CARE UNIT	17, 404, 329		17, 404, 329			32.00
	2060 NEONATAL INTENSIVE CARE UNIT	17, 315, 512		17, 315, 512			35. 00
	100 SUBPROVI DER – I RF	6, 019, 532		6, 019, 532			41.00
	200 SUBPROVI DER	4 5/4 000		4 5/4 000			42.00
	300 NURSERY CLLLARY SERVICE COST CENTERS	4, 564, 000		4, 564, 000			43. 00
	0000 OPERATING ROOM	83, 524, 657	117, 507, 422	201, 032, 079	0. 095098	0. 000000	50.00
	5001 CV SURGERY	03, 324, 037	117, 307, 422			0. 000000	
	5100 RECOVERY ROOM	9, 404, 093	21, 909, 592			0. 000000	
	5200 DELIVERY ROOM & LABOR ROOM	35, 527, 941	4, 033, 735			0. 000000	
	3300 ANESTHESI OLOGY	00,02,,,,,	0		0. 000000	0. 000000	
	5400 RADI OLOGY-DI AGNOSTI C	15, 509, 658	29, 598, 924			0. 000000	
	5500 RADI OLOGY-THERAPEUTI C	4, 436, 292	94, 526, 232			0. 000000	
	6600 RADI OI SOTOPE	0	0			0.000000	
57. 00 05	5700 CT SCAN	9, 446, 578	17, 367, 744	26, 814, 322		0.000000	57. 00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	2, 436, 222	6, 423, 642			0.000000	58. 00
59. 00 05	900 CARDI AC CATHETERI ZATI ON	22, 717, 911	40, 882, 192	63, 600, 103	0. 045891	0.000000	59. 00
60.00 06	0000 LABORATORY	41, 114, 612	55, 437, 434	96, 552, 046	0. 156360	0.000000	60.00
64.00 06	400 INTRAVENOUS THERAPY	0	0	C	0.000000	0.000000	64. 00
	500 RESPI RATORY THERAPY	12, 130, 648	2, 449, 598	14, 580, 246	0. 279789	0.000000	65. 00
	6600 PHYSI CAL THERAPY	13, 819, 386	15, 475, 224	29, 294, 610		0.000000	
	700 OCCUPATI ONAL THERAPY	0	0	C		0. 000000	
	800 SPEECH PATHOLOGY	0	0			0. 000000	
	9900 ELECTROCARDI OLOGY	11, 516, 935	10, 350, 831			0. 000000	
	OOO ELECTROENCEPHALOGRAPHY	2, 608, 872	11, 608, 910			0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 604, 451	48, 052, 772			0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS	72, 305, 255	45, 134, 728			0. 000000	
	7300 DRUGS CHARGED TO PATIENTS	70, 971, 070	105, 347, 471			0.000000	
	7302 OP PHARMACY	2 022 452	720 542	1	0.000000	0.000000	
	7400 RENAL DIALYSIS	3, 923, 453	730, 562			0.000000	
	/500 ASC (NON-DISTINCT PART) 350 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			0. 000000 0. 000000	
	7697 CARDI AC REHABI LI TATI ON	400, 999	2, 692, 905	1			
	TPATIENT SERVICE COST CENTERS	400, 999	2, 092, 903	3, 093, 904	0.410343	0. 000000	70.97
	2000 CLINIC	15, 118	2, 784, 001	2, 799, 119	0. 946836	0. 000000	90.00
	0001 OP ONCOLOGY INFUSION CENTER	1, 962, 365	15, 556, 249			0. 000000	
	2002 WOUND CARE CENTER	7, 265	6, 326, 661			0. 000000	
	2003 PAIN CLINIC	323	2, 902, 269			0. 000000	
	0005 OP PSYCH CLINIC	8, 297	2, 485, 026			0. 000000	
	2100 EMERGENCY	44, 773, 253	152, 748, 104			0. 000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 837, 868	27, 983, 699			0.000000	
	THER REIMBURSABLE COST CENTERS						
	2400 HOME PROGRAM DIALYSIS	0	0	C	0.000000	0.000000	94. 00
	2500 AMBULANCE SERVICES	244, 421	45, 408, 636	45, 653, 057		0.000000	95. 00
100.0010	0000 I&R SERVICES-NOT APPRVD PRGM	0	0	C			100.00
101.00 10	0100 HOME HEALTH AGENCY	0	0	C			101. 00
	PECIAL PURPOSE COST CENTERS						
	300 I NTEREST EXPENSE						113. 00
	400 UTI LI ZATI ON REVI EW-SNF						114. 00
	500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115. 00
	600 HOSPI CE	0	0	0			116. 00
200.00	Subtotal (see instructions)	680, 900, 276	885, 724, 563	1, 566, 624, 839			200. 00
201.00	Less Observation Beds	, oo ooo oo	005 704 5:-	4 5// /0/ 5==			201. 00
202. 00	Total (see instructions)	680, 900, 276	885, 724, 563	1, 566, 624, 839	1		202. 00

					5/28/2019 12:09 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35. 00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42. 00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 095098			50.00
50. 01	05001 CV SURGERY	0. 000000			50. 01
51.00	05100 RECOVERY ROOM	0. 190429			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 200080			52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 152553			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 065279			55. 00
56. 00	05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00	05700 CT SCAN	0. 050443			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 086981			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 045891			59. 00
60.00	06000 LABORATORY	0. 156360			60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 279789			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 408417			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 408417			67. 00
68. 00	1 1	1			68. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0. 000000			
69. 00		0. 078703			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 130215			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199017			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 226806			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 193855			73.00
73. 01	07302 OP PHARMACY	0.000000			73. 01
	07400 RENAL DIALYSIS	0. 336916			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 416345			76. 97
00.05	OUTPATIENT SERVICE COST CENTERS	0.04400			20.55
90.00	09000 CLINIC	0. 946836			90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 267758			90. 01
90. 02	09002 WOUND CARE CENTER	0. 193620			90. 02
90. 03	09003 PAIN CLINIC	0. 199546			90. 03
90. 05	09005 OP PSYCH CLINIC	1. 337545			90. 05
91. 00	09100 EMERGENCY	0. 066320			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 181113			92. 00
	OTHER REIMBURSABLE COST CENTERS				
94.00	1 1	0. 000000			94.00
	09500 AMBULANCE SERVICES	0. 218618			95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100. 00
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116.00	11600 HOSPI CE				116. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00
		. '			•

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 12:09 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 59, 873, 185 59, 873, 185 8.440 59, 881, 625 7, 028, 626 03100 INTENSIVE CARE UNIT 7,028,626 7, 028, 626 31.00 31.00 03200 CORONARY CARE UNIT o 32.00 5, 426, 928 5, 426, 928 5, 426, 928 32.00 02060 NEONATAL INTENSIVE CARE UNIT 4.348.204 4. 348. 204 4, 348, 204 35.00 0 35, 00 04100 SUBPROVIDER - IRF 41.00 2, 539, 110 2, 539, 110 0 2, 539, 110 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 1, 580, 576 1, 580, 576 1, 580, 576 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19, 117, 834 19, 117, 834 0 19, 117, 834 50.00 50.01 05001 CV SURGERY 0 50.01 0 51.00 05100 RECOVERY ROOM 5, 963, 038 5, 963, 038 5, 963, 038 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 915, 506 7, 915, 506 7, 915, 506 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 6, 881, 436 6, 881, 436 54.00 0 6, 881, 436 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 6, 460, 144 6, 460, 144 6, 460, 144 55 00 56.00 05600 RADI OI SOTOPE Λ 56.00 57.00 05700 CT SCAN 1, 352, 585 1, 352, 585 1, 352, 585 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 770, 638 770, 638 770, 638 58.00 05900 CARDIAC CATHETERIZATION 2, 918, 645 2, 918, 645 2 918 645 59 00 59 00 0 60.00 06000 LABORATORY 15, 096, 915 15, 096, 915 15, 096, 915 60.00 06400 INTRAVENOUS THERAPY 64.00 0 0 64.00 65 00 06500 RESPIRATORY THERAPY 4.079.391 4.079.391 4, 079, 391 65 00 06600 PHYSI CAL THERAPY 66.00 11, 964, 408 11, 964, 408 11, 964, 408 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 0 0 06900 ELECTROCARDI OLOGY 69 00 1, 721, 058 1, 721, 058 1, 721, 058 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 1, 851, 362 1, 851, 362 1, 851, 362 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 057, 094 15, 057, 094 15, 057, 094 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26, 636, 143 26, 636, 143 26, 636, 143 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 34, 180, 145 34, 180, 145 34, 180, 145 73 00 73.01 07302 OP PHARMACY 0 Ω 73.01 07400 RENAL DIALYSIS 0 74.00 1, 568, 010 1, 568, 010 1, 568, 010 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75.01 0 0 0 75 01 1, 288, 130 07697 CARDIAC REHABILITATION 1, 288, 130 1, 288, 130 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2, 650, 308 2, 650, 308 90.00 0 2, 650, 308 09001 OP ONCOLOGY INFUSION CENTER 4, 690, 744 4, 690, 744 4, 690, 744 90.01 0 90 01 90.02 09002 WOUND CARE CENTER 1, 226, 374 1, 226, 374 0 1, 226, 374 90.02 90. 03 09003 PAIN CLINIC 579, 201 579, 201 0 579, 201 90.03 09005 OP PSYCH CLINIC 3, 327, 922 3, 327, 922 7,009 3, 334, 931 90.05 90.05 09100 EMERGENCY 91.00 13, 099, 685 13, 099, 685 13, 099, 685 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 5, 582, 193 5, 582, 193 5, 582, 193 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS Λ 94 00 95. 00 09500 AMBULANCE SERVICES 9, 980, 577 9, 980, 577 9, 980, 577 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 C 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 \cap 0 115, 00

286, 756, 115

281, 173, 922

5, 582, 193

286, 756, 115

281, 173, 922

5, 582, 193

0 116.00

286, 771, 564 200. 00

281, 189, 371 202. 00

5, 582, 193 201. 00

15, 449

15. 449

116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051

						5/28/2019 12:	09 pm
	,			e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
		6. 00	7. 00	8. 00	9. 00	Rati o 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00		123, 652, 604		123, 652, 604			30.00
31. 00	1	22, 696, 356		22, 696, 356			31.00
32. 00		17, 404, 329		17, 404, 329			32. 00
35.00		17, 315, 512		17, 315, 512			35. 00
41.00		6, 019, 532		6, 019, 532			41. 00
42.00	04200 SUBPROVI DER	0		C			42.00
43.00		4, 564, 000		4, 564, 000			43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00		83, 524, 657	117, 507, 422			0. 000000	
50. 01		0	0			0. 000000	
51.00		9, 404, 093	21, 909, 592			0.000000	
52.00		35, 527, 941	4, 033, 735	1		0.000000	
53. 00 54. 00	1	15 500 450	0 29, 598, 924		0. 000000 0. 152553	0. 000000 0. 000000	
55. 00		15, 509, 658 4, 436, 292	94, 526, 232			0. 000000	
56. 00		4, 430, 292	94, 520, 232		1	0. 000000	
57. 00		9, 446, 578	17, 367, 744			0. 000000	
58. 00		2, 436, 222	6, 423, 642			0. 000000	
59. 00		22, 717, 911	40, 882, 192			0. 000000	
60.00	1	41, 114, 612	55, 437, 434			0. 000000	
64.00		0	0			0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	12, 130, 648	2, 449, 598	14, 580, 246	0. 279789	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 819, 386	15, 475, 224	29, 294, 610	0. 408417	0.000000	66. 00
67. 00		0	0	C		0. 000000	
68. 00		0	0			0. 000000	
69. 00	1	11, 516, 935	10, 350, 831			0. 000000	
70. 00		2, 608, 872	11, 608, 910			0. 000000	
71. 00		27, 604, 451	48, 052, 772			0. 000000	
72.00		72, 305, 255	45, 134, 728			0.000000	
73. 00 73. 01	1	70, 971, 070	105, 347, 471 0		0. 193855 0. 000000	0.000000	
74. 00		3, 923, 453	730, 562	· -	1	0. 000000 0. 000000	
75. 00		3, 723, 433	730, 302		l	0. 000000	
75. 00			0		1	0. 000000	
76. 97	1	400, 999	2, 692, 905	1		0. 000000	
	OUTPATIENT SERVICE COST CENTERS	,					
90.00		15, 118	2, 784, 001	2, 799, 119	0. 946836	0. 000000	90.00
90. 01	1	1, 962, 365	15, 556, 249			0. 000000	
90. 02		7, 265	6, 326, 661		1	0. 000000	
90. 03		323	2, 902, 269			0. 000000	
90.05	1	8, 297	2, 485, 026			0.000000	
91.00		44, 773, 253	152, 748, 104			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 837, 868	27, 983, 699	30, 821, 567	0. 181113	0. 000000	92. 00
94 00	09400 HOME PROGRAM DI ALYSI S		0		0. 000000	0. 000000	94. 00
	09500 AMBULANCE SERVICES	244, 421	45, 408, 636	45, 653, 057		0. 000000	
	0 10000 I &R SERVI CES-NOT APPRVD PRGM	211, 121	0, 100, 000	(10, 000, 007	0.210010	0.00000	100.00
	0 10100 HOME HEALTH AGENCY	o	0	d)		101. 00
	SPECIAL PURPOSE COST CENTERS	·	-]
113.00	0 11300 INTEREST EXPENSE						113. 00
	0 11400 UTILIZATION REVIEW-SNF						114. 00
	0 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115. 00
	0 11600 H0SPI CE	0	0	C			116. 00
200.00		680, 900, 276	885, 724, 563	1, 566, 624, 839	'		200. 00
201.00		(00,000,07)	005 704 510	1 5// /04 600			201. 00
202.00	0 Total (see instructions)	680, 900, 276	885, 724, 563	1, 566, 624, 839	1 1		202. 00

					5/28/2019 12:0	09 pm_
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
32. 00	03200 CORONARY CARE UNIT					32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT					35. 00
41. 00	04100 SUBPROVI DER - I RF					41. 00
42. 00	04200 SUBPROVI DER					42. 00
43. 00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS	0.005000				
50. 00	05000 OPERATING ROOM	0. 095098				50. 00
50. 01	05001 CV SURGERY	0. 000000				50. 01
51. 00	05100 RECOVERY ROOM	0. 190429				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 200080				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 152553				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 065279				55. 00
56.00	05600 RADI OI SOTOPE	0. 000000				56. 00
57. 00	05700 CT SCAN	0. 050443				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 086981				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 045891				59. 00
60.00	06000 LABORATORY	0. 156360				60.00
64. 00	06400 NTRAVENOUS THERAPY	0.000000				64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 279789				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 408417				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 078703				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 130215				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199017				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 226806				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 193855				73. 00
73. 01	07302 OP PHARMACY	0. 000000				73. 01
74. 00	07400 RENAL DIALYSIS	0. 336916				74. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
75. 00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0. 000000				75. 00
	1 1	1				
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 416345				76. 97
	OUTPATIENT SERVICE COST CENTERS	0.044004				
	09000 CLI NI C	0. 946836				90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 267758				90. 01
90. 02	09002 WOUND CARE CENTER	0. 193620				90. 02
90. 03	09003 PAIN CLINIC	0. 199546				90. 03
90. 05	09005 OP PSYCH CLINIC	1. 337545				90. 05
91.00	09100 EMERGENCY	0. 066320				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 181113				92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>				
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000				94. 00
95. 00	1 1	0. 218618				95. 00
	10000 I &R SERVI CES-NOT APPRVD PRGM	0.210010				100.00
	10100 HOME HEALTH AGENCY					101. 00
101.00						101.00
110 00	SPECIAL PURPOSE COST CENTERS					112 00
	11300 NTEREST EXPENSE					113. 00
	11400 UTI LI ZATI ON REVI EW-SNF					114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
	11600 HOSPI CE					116. 00
200.00						200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00
		. '				-

Health Financial Systems I U HEALTH BLOG CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2018 | Part I I | To | 12/31/2018 | Date/Time | Prepared: Provider CCN: 15-0051

				10	12/31/2010	5/28/2019 12:	
			Ti tl	e XIX	Hospi tal	PPS	o, b
	Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
	, , , , , , , , , , , , , , , , , , ,			Net of Capital	Reduction	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		,	ĺ	col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS					•	
50.00	05000 OPERATING ROOM	19, 117, 834	1, 429, 068	17, 688, 766	0	0	50. 00
50. 01	05001 CV SURGERY	0	0	0	0	0	50. 01
	05100 RECOVERY ROOM	5, 963, 038	175, 361	5, 787, 677	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 915, 506			0	l 0	52.00
	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 881, 436	546, 061	6, 335, 375	0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	6, 460, 144	569, 261		0	0	55. 00
	05600 RADI 0I S0T0PE	0	0		0	0	56.00
	05700 CT SCAN	1, 352, 585	46, 869	1, 305, 716	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	770, 638	52, 646	,	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	2, 918, 645	190, 313		0	0	59. 00
	06000 LABORATORY	15, 096, 915			0	Ö	60.00
	06400 I NTRAVENOUS THERAPY	10,070,710	002, 710		0	Ö	64. 00
	06500 RESPIRATORY THERAPY	4, 079, 391	81, 727	1	0	0	65.00
	06600 PHYSI CAL THERAPY	11, 964, 408	362, 897		0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	11, 704, 400	0 302, 047	1	0		67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	1, 721, 058	80, 712	1, 640, 346	0	0	69.00
					0	0	70.00
	07000 ELECTROENCEPHALOGRAPHY	1, 851, 362	117, 341		0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	15, 057, 094	201, 797		0	1	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	26, 636, 143	353, 394		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	34, 180, 145	488, 577		0	0	73. 00
	07302 OP PHARMACY	1 5/0 010	0	1	0	0	73. 01
	07400 RENAL DI ALYSI S	1, 568, 010			0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	1	0	0	75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1	0	0	75. 01
	07697 CARDI AC REHABI LI TATI ON	1, 288, 130	100, 188	1, 187, 942	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	0 (50 000	200 050	0.040.054			00.00
	09000 CLINIC	2, 650, 308			0		90.00
	09001 OP ONCOLOGY INFUSION CENTER	4, 690, 744	142, 217		0	1	90. 01
	09002 WOUND CARE CENTER	1, 226, 374	121, 829		0	0	90. 02
	09003 PAIN CLINIC	579, 201	74, 080		0	0	90. 03
	09005 OP PSYCH CLINIC	3, 327, 922	308, 732		0	0	90. 05
	09100 EMERGENCY	13, 099, 685			0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 582, 193	340, 391	5, 241, 802	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						04.00
	09400 HOME PROGRAM DIALYSIS	0	0	1	0		
	09500 AMBULANCE SERVICES	9, 980, 577	440, 207		0		
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	1 1	0		100.00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						1110 00
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF		_		_	_	114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
	11600 HOSPI CE	0	0	0	0		116. 00
200.00		205, 959, 486			0		200. 00
201.00		5, 582, 193			0		201. 00
202. 00	Total (line 200 minus line 201)	200, 377, 293	8, 431, 832	191, 945, 461	0	0	202. 00

Peri od: Worksheet C
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm Provider CCN: 15-0051 REDUCTIONS FOR MEDICALD ONLY

Cost Center Description							5/28/2019 12:09 p	pm
Capital and Reduction Capital and Reduction Capital Ratio (col. 6 Reduction Capital Ratio (col. 6 Reduction Capital Ratio (col. 6 Reduction Capital Ratio (col. 7) Capital Ratio					e XIX	Hospi tal	PPS	
ANCILLARY SERVICE COST CENTERS		Cost Center Description		Total Charges	Outpati ent			
Reduction 8)				(Worksheet C,	Cost to Charge			
ANCILLARY SERVICE COST CENTERS								
## ANCILLARY SERVICE COST CENTERS 50. 00 GOOD OPERATING ROM								
50. 00 050000 OFERATI NG ROOM			6. 00	7. 00	8. 00			
50.01 05001 CV SURGERY 0								
51.00	50.00	05000 OPERATI NG ROOM	19, 117, 834	201, 032, 079	0. 095098		50.). 00
52.00 05200 0514PEY ROOM & LABOR ROOM 7, 915, 506 0, 000000 53.00 53.00 05300 081500 08150 06500 08150 06500 081500 0	50. 01		_				50.). 01
53.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 55.00	51.00		5, 963, 038				51.	. 00
54. 00 05400 ABDIOLOGY-DIAGNOSTIC	52.00		7, 915, 506	39, 561, 676	0. 200080		52.	2. 00
55.00 OSDO RADIO LOCY-THERAPEUTIC 6, 460, 144 98, 962, 524 0, 065279 55.00 56.00 05600 RADIO LOCY-THERAPEUTIC 0 0 0, 0000000 56.00 05600 RADIO LOCY CRAN 57.00 05700 CT SCAN 57.00 05700 CT SCAN 57.00 05800 OSBO MAGNETIC RESONANCE IMAGING (MRI) 77.0 638 88.99 84.0 05900 CARDIO LAC CATHETERI ZATI ON 2, 918. 645 63, 600, 103 0, 045891 59.00 06.00 05900 CARDIO LAC CATHETERI ZATI ON 2, 918. 645 63, 600, 103 0, 045891 59.00 06.00 05900 LABORATORY 15, 096, 915 0 0, 55.20, 646 00.00 06.00	53.00		0	0	0.000000		53.	3. 00
56.00 05600 RADIO I SOTOPE 1	54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 881, 436	45, 108, 582	0. 152553		54.	. 00
57.00 05700 CT SCAN 57.00 CT SCAN 57.00 CT SCAN 58.00 CS00 MAGNETIC RESONANCE IMAGING (MRI) 770, 638 8.895 864, 0 0.86981 58.00 0.89081 58.00 0.89081 58.00 0.89081 59.00 0.89081 59.00 0.89081 59.00 0.800 0.8000 CARDINA CATHETERI ATTION 2.918, 645 63.600, 103 0.045891 59.00 0.00000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.6000 0.000000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.0			6, 460, 144	98, 962, 524	0. 065279		55.	i. 00
SB 00 OSBOO MARKETI C RESONANCE I MAGING (MRI) 7.770, 638 8.859, 864 0.086/981 59.00 60.00 0.0000 CARDIAC CATHETERIZATION 2.918, 645 63, 600, 103 0.045891 59.00 60.00 0.00000 0.000000 0.000000 0.40 0.000000 0.40 0.000000 0.40 0.000000 0.000000 0.40 0.000000 0.0000000 0.40 0.000000 0.0000000 0.40 0.000000 0.0000000 0.40 0.000000 0.000000 0.65 0.00 0.000000 0.40 0.000000 0.40 0.000000 0.65 0.00 0.000000 0.000000 0.65 0.00 0.000000 0.000000 0.65 0.00 0.000000 0.000000 0.65 0.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			0	0	0.000000			
59, 00 05900 CARDIAC CATHETER ZATION 2, 918, 645 63, 600, 103 0. 045891 59, 00	57.00		1, 352, 585	26, 814, 322	0. 050443		57.	. 00
60.00 06000 LABORATORY 15,096,915 96,552,046 0.156350 06.00 06		05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 086981		58.	3. 00
64. 00 06400 INTRAVENDUS THERAPY 0 0 0.000000 065. 00 06500 RESPIRATORY THERAPY 4, 079, 391 14, 580, 246 0.279789 65. 00 06600 PHYSI CAL THERAPY 11, 964, 408 29, 294, 610 0.408417 66. 00 067. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0.000000 067. 00 068. 00 06800 SPECCH PATHOLOGY 0 0 0.000000 068. 00 06800 SPECCH PATHOLOGY 1, 721, 058 21, 867, 766 0.078703 069. 00 070. 00 107000 LEICTROCARDI OLOGY 1, 721, 058 21, 867, 766 0.078703 069. 00 07000 LEICTROCARDI OLOGY 1, 721, 058 21, 867, 766 0.078703 069. 00 07000 LEICTROCARDI OLOGY 1, 721, 058 21, 867, 766 0.078703 070. 00 07000 LEICTROCARDI OLOGY 1, 721, 058 21, 867, 766 0.078703 070. 00 07000 LEICTROCARDI OLOGY 0.07200 0.07200 LEICTROCARDI OLOGY 0.072000 0.072000 0.07200 0.07200 0.07200 0.07200 0.07200	59.00	05900 CARDI AC CATHETERI ZATI ON	2, 918, 645	63, 600, 103	0. 045891		59.). 00
65. 00 06500 RESPIRATORY THERAPY	60.00	06000 LABORATORY	15, 096, 915	96, 552, 046	0. 156360		60.). 00
66.00 06600 06000 06000 06000 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 068000 0680000 068000 068000 0680000 0680000 0680000 0680000 0680000 0680000 0680000 0680000 06800000 06800000 06800000 06800000 06800000 068000000 068000000 068000000 068000000 0680000000 0680000000 06800000000 0680000000000	64.00	06400 I NTRAVENOUS THERAPY	0	0	0.000000		64.	1. 00
67. 00 06700 05CUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	4, 079, 391	14, 580, 246	0. 279789		65.	i. 00
68. 00 069000 0690000 0690000 069000 069000 0690000 0690000 0690000 0690000 0690000 0690000 06900000 0690000 0690000 06900000 06900000 06900000 06900000 06900000 06900000 06900000 069000000 069000000 069000000 0690000000 0690000000000	66.00	06600 PHYSI CAL THERAPY	11, 964, 408	29, 294, 610	0. 408417		66.	o. 00
69.00 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 0690000 069000 069000 0690000 0690000 0690000 0690000 0690000 0690000 0690000 0690000 0690000 0690000 0690000 0690000 06900000 06900000 06900000 06900000 069000000 069000000 069000000 069000000000 0690000000000	67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.000000		67.	. 00
70. 00 07000 ELECTROENCEPHALLOGRAPHY 1, 851, 362 14, 217, 782 0, 130215 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 15, 057, 094 75, 657, 223 0, 199017 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 00 75. 00	68. 00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.	3. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 15, 057, 094 75, 657, 223 0. 199017 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 26, 636, 143 117, 439, 983 0. 226806 72. 00 73. 00 75. 00	69. 00	06900 ELECTROCARDI OLOGY	1, 721, 058	21, 867, 766	0. 078703		69.). 00
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS	70.00	07000 ELECTROENCEPHALOGRAPHY	1, 851, 362	14, 217, 782	0. 130215		70.). 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 34, 180, 145 176, 318, 541 0.193855 73. 00 73. 01 07300 DP HARMACY 0 0 0.000000 73. 01 73. 01 73. 01 73. 01 73. 01 73. 00 74. 00 07400 RENAL DI ALYSIS 1, 568, 010 4, 654, 015 0.336916 74. 00 75. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 75. 01 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 75. 01	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 057, 094	75, 657, 223	0. 199017		71.	. 00
73. 01 07302 OP PHARMACY	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	26, 636, 143	117, 439, 983	0. 226806		72.	2. 00
74. 00 07400 RENAL DI ALYSIS 1,568,010 4,654,015 0.336916 74. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 0.3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 75. 00 76. 97 76. 97 76.97		07300 DRUGS CHARGED TO PATIENTS	34, 180, 145	176, 318, 541	0. 193855		73.	3. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	73. 01	07302 OP PHARMACY	0	0	0.000000		73.	3. 01
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0			1, 568, 010	4, 654, 015			74.	1. 00
76. 97 07697 CARDI AC REHABILITATION 1, 288, 130 3, 093, 904 0, 416345 90. 00 0000 CLI NI C 2, 650, 308 2, 799, 119 0, 946836 90. 01 09001 DP ONCOLOGY INFUSION CENTER 4, 690, 744 17, 518, 614 0, 267758 90. 01 90002 00002 WOUND CARE CENTER 1, 226, 374 6, 333, 926 0, 193620 90. 02 90. 03 09003 PAIN CLI NI C 579, 201 2, 902, 592 0, 199546 90. 03 09005 DP PSYCH CLI NI C 3, 327, 922 2, 493, 323 1, 334734 90. 05 90. 05 09005 DP PSYCH CLI NI C 3, 327, 922 2, 493, 323 1, 334734 90. 05 90. 05 09000 BSERVATI ON BEDS (NON-DI STI NCT PART) 5, 582, 193 30, 821, 567 0, 181113 92. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 5, 582, 193 30, 821, 567 0, 181113 92. 00 09400 HOME PROGRAM DI ALYSI S 9, 980, 577 45, 653, 057 0, 218618 95. 00 09500 AMBULANCE SERVI CES 9, 980, 577 45, 653, 057 0, 218618 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0. 000000 101. 00 10100 HOME HEALTH AGENCY 0 0 0. 000000 101. 00 10100 HOME HEALTH AGENCY 0 0 0. 000000 111. 00 SPECIAL PURPOSE COST CENTERS 1114. 00 111400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0. 000000 115. 00 0. 000000 116. 00 0. 000000 116. 00 0. 000000 0. 000000 0. 000000 0. 000000		07500 ASC (NON-DISTINCT PART)	0	0	0.000000		75.	i. 00
90. 00 09000 CLINIC 2,650,308 2,799,119 0.946836 90. 01 09001 0P ONCOLOGY INFUSION CENTER 4,690,744 17,518,614 0.267758 90. 01 09002 WOUND CARE CENTER 1,226,374 6,333,926 0.193620 90. 02 09002 WOUND CARE CENTER 1,226,374 6,333,926 0.193620 90. 02 090			0	0	0.000000		75.	i. 01
90. 00	76. 97	07697 CARDI AC REHABILI TATI ON	1, 288, 130	3, 093, 904	0. 416345		76	າ. 97
90. 01		OUTPATIENT SERVICE COST CENTERS						
90. 02			2, 650, 308	2, 799, 119	0. 946836			
90. 03	90. 01	09001 OP ONCOLOGY INFUSION CENTER	4, 690, 744	17, 518, 614	0. 267758		90.). 01
90. 05	90. 02	09002 WOUND CARE CENTER	1, 226, 374	6, 333, 926	0. 193620		90.). 02
91. 00 09100 EMERGENCY 13, 099, 685 197, 521, 357 0. 066320 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 5, 582, 193 30, 821, 567 0. 181113 92. 00 00 00 00 00 00 00 00	90. 03		579, 201	2, 902, 592			90.). 03
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 5,582,193 30,821,567 0.181113 92. 00 OTHER REIMBURSABLE COST CENTERS 0 0 0.000000 94. 00 95. 00 09500 AMBULANCE SERVI CES 9,980,577 45,653,057 0.218618 95. 00 100. 00 16R SERVI CES-NOT APPRVD PRGM 0 0 0.000000 100. 00 100.								
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O								
94. 00 95. 00 100.00 10	92.00		5, 582, 193	30, 821, 567	0. 181113		92	2. 00
95. 00 09500 AMBULANCE SERVI CES 9, 980, 577 45, 653, 057 0. 218618 95. 00 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0. 0000000 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0. 0000000 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILI ZATI ON REVI EW-SNF 115. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0. 000000 116. 00 116. 00 116. 00 11600 HOSPI CE 0 0 0. 000000 116. 00 116. 00 116. 00 Subtotal (sum of lines 50 thru 199) 205, 959, 486 1, 374, 972, 506 200. 00 201. 00 20								
100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0			1	-				
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0			9, 980, 577	45, 653, 057				
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVIEW-SNF 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0.000000 115.00 115.00 116.00 11600								
113. 00	101.00		0	0	0. 000000		101	. 00
114.00								
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0.0000000 115. 00 116.								
116. 00 11600 HOSPICE								
200.00 Subtotal (sum of lines 50 thru 199) 205,959,486 1,374,972,506 200.00 201.00 Less Observation Beds 5,582,193 0 201.00			0	0				
201.00 Less Observation Beds 5, 582, 193 0 201.00			0	0				
202. 00 Total (line 200 minus line 201) 200, 377, 293 1, 374, 972, 506 202. 00	202.00	Total (line 200 minus line 201)	200, 377, 293	1, 374, 972, 506			202	·. 00

Health Financial Systems	11	J HEALTH BLOOMI	NCTON HOSDITAL		In Lie	eu of Form CMS-:	2552 10
APPORTIONMENT OF INPATIENT ROL			Provider C	CN: 15-0051	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part I	pared:
			Title	XVIII	Hospi tal	PPS	
Cost Center Descri	ption	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col			
		26)		2)			
		1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVI	CE COST CENTERS						
30. 00 ADULTS & PEDIATRICS		3, 651, 479	0	3, 651, 47	9 48, 423	75. 41	30. 00
31.00 INTENSIVE CARE UNIT		350, 872		350, 87	2 4, 035	86. 96	31.00
32.00 CORONARY CARE UNIT		393, 022		393, 02	2 3, 424	114. 78	32.00
35.00 NEONATAL INTENSIVE CARE	UNI T	217, 431		217, 43	1 3, 748	58. 01	35. 00
41. 00 SUBPROVI DER - I RF		318, 168	0	318, 16	2, 834	112. 27	41.00
42. 00 SUBPROVI DER		0	0		0 0	0.00	42. 00
43.00 NURSERY		106, 140		106, 14	0 3, 495	30. 37	43.00
200.00 Total (lines 30 through	199)	5, 037, 112		5, 037, 11	2 65, 959		200. 00
Cost Center Descri	,	Inpatient	Inpatient		<u> </u>		
	•		ς.				

	COST CERTEE DESCRIPTION	Program days	Program Capital Cost (col. 5 x col.		
		6.00	6) 7. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS				_
30.00	ADULTS & PEDIATRICS	18, 260	1, 376, 987	30. C	0
31.00	INTENSIVE CARE UNIT	2, 121	184, 442	31.0	0
32.00	CORONARY CARE UNIT	1, 686	193, 519	32.0	0
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35. C	0
41.00	SUBPROVI DER - I RF	1, 850	207, 700	41.0	0
42.00	SUBPROVI DER	0	0	42.0	0
43.00	NURSERY	0	0	43.0	0
200.00	Total (lines 30 through 199)	23, 917	1, 962, 648	200. 0	00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II	narod:
				10 12/31/2018	Date/Time Pre 5/28/2019 12:	pareu: 09 pm
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLLI ADV. CEDIU OF COCT. CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 420 040	201 022 070	0.00710	2/ 5/4 505	250,020	F0 00
•	1, 429, 068		I		259, 938	
50. 01 05001 CV SURGERY 51. 00 05100 RECOVERY ROOM	175 2/1	_			0	50. 01 51. 00
52. 00 05100 RECOVERY ROOM LABOR ROOM	175, 361 861, 744		1		23, 389 2, 632	
53. 00 05300 ANESTHESI OLOGY	001, 744	39, 561, 676	1		2,032	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	546, 061	_			97, 799	
55. 00 05500 RADI OLOGY - THERAPEUTI C	569, 261	98, 962, 524	1		14, 198	1
56. 00 05600 RADI 01 SOTOPE	309, 201	90, 902, 324	1		14, 190	1
57. 00 05700 CT SCAN	46, 869	ļ			8, 133	
58.00 05700 CT 3CAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	52, 646				6, 302	
59. 00 05900 CARDI AC CATHETERI ZATI ON	190, 313		1		26, 692	
60. 00 06000 LABORATORY	562, 943				101, 131	60.00
64. 00 06400 I NTRAVENOUS THERAPY	302, 743	70, 332, 040	0.00000		0	1
65. 00 06500 RESPIRATORY THERAPY	81, 727	14, 580, 246			32, 836	
66. 00 06600 PHYSI CAL THERAPY	362, 897					
67. 00 06700 OCCUPATI ONAL THERAPY	302,077		1		0.007	67. 00
68. 00 06800 SPEECH PATHOLOGY			1		0	1
69. 00 06900 ELECTROCARDI OLOGY	80, 712	_			22, 475	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	117, 341		0. 00825		11, 198	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	201, 797					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	353, 394					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	488, 577		1		88, 171	
73. 01 07302 OP PHARMACY	0	0	0.00000		0	73. 01
74. 00 07400 RENAL DIALYSIS	35, 028	4, 654, 015	1		18, 158	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	i		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.00000	00	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	100, 188	3, 093, 904	0. 03238	199, 900	6, 473	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	280, 952	2, 799, 119	0. 10037	10, 370	1, 041	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	142, 217				7, 536	90. 01
90. 02 09002 WOUND CARE CENTER	121, 829			•	104	90. 02
90. 03 09003 PAIN CLINIC	74, 080				7	90. 03
90. 05 09005 OP PSYCH CLINIC	308, 732				471	90. 05
91. 00 09100 EMERGENCY	807, 888					1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	340, 391	30, 821, 567	0. 01104	1, 487, 201	16, 425	92. 00
OTHER REIMBURSABLE COST CENTERS	_	-		-	_	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00	0	1
95. 00 09500 AMBULANCE SERVICES	0 222 244	1 220 210 440		204 (10 522	1 017 /74	95. 00
200.00 Total (lines 50 through 199)	8, 332, 016	1, 329, 319, 449	Ί	204, 619, 539	1, 017, 671	J∠UU. UU

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
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From 01/01/2018 Part To 12/31/2018 Part Date 5/28.	sheet D III /Time Prepared: /2019 12: 09 pm PPS Other dical :ion Cost 3.00	ed:
Nursing School Nursing School Allied Health Post-Stepdown Adjustments Adju	Other dical ion Cost	
Post-Stepdown Adjustments dical ion Cost		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00	
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 31. 00 03100 I NTENSI VE CARE UNI T 0 0 0 0 0		
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	0 30.0 0 31.0 0 32.0 0 35.0 0 41.0 0 42.0 0 200.0 atient	. 00 . 00 . 00 . 00
instructions) minus col. 4)		
	3. 00	
30. 00 03000 ADULTS & PEDIATRICS 0 0 48, 423 0.00 31. 00 03100 INTENSI VE CARE UNIT 0 4, 035 0.00 32. 00 03200 CORONARY CARE UNIT 0 3, 424 0.00 35. 00 02060 NEONATAL INTENSI VE CARE UNIT 0 3, 748 0.00 41. 00 04100 SUBPROVI DER IRF 0 0 2, 834 0.00 42. 00 04200 SUBPROVI DER 0 0 0 0.00 43. 00 04300 NURSERY 0 3, 495 0.00 200. 00 Total (Lines 30 through 199) 0 65, 959	18, 260 30. 0 2, 121 31. 0 1, 686 32. 0 0 35. 0 1, 850 41. 0 0 42. 0 0 43. 0 23, 917 200. 0	. 00 . 00 . 00 . 00
Cost Center Description I npatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0	30.0	. 00
31. 00 03100 INTENSI VE CARE UNIT 0 03200 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 0	30. 0 31. 0 32. 0 35. 0 41. 0 42. 0 43. 0 200. 0	. 00 . 00 . 00 . 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Provider CCN: 15-0051 THROUGH COSTS

				0 12/31/2018	5/28/2019 12:	
		Ti tl e	e XVIII	Hospi tal	PPS	0 / p
Cost Center Description	Non Physician			Allied Health		
'	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	(C) (0	0	50. 00
50. 01 05001 CV SURGERY) (0	0	50. 01
51.00 05100 RECOVERY ROOM		ol c		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		ol c		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		ol c		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		ol c		0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		ol c		o	0	55. 00
56. 00 05600 RADI 0I SOTOPE		ol c		0	0	56. 00
57.00 05700 CT SCAN		ol c) (o	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		ol c) (o	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		ol c) (o	0	59. 00
60. 00 06000 LABORATORY		ol c) (o	0	60.00
64.00 06400 INTRAVENOUS THERAPY		ol c) (o	0	64.00
65. 00 06500 RESPIRATORY THERAPY		o c) (0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		ol c) (o	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		o c) (0	0	67. 00
68.00 06800 SPEECH PATHOLOGY) c) (0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY) c) (0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY) c) (0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	() c) (0	0	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS) c) (0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS) c) (0	474, 333	73. 00
73. 01 07302 OP PHARMACY) c) (0	0	73. 01
74. 00 07400 RENAL DI ALYSI S) C) (0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)) C) (0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			0	0	0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON) <u> </u>) (0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		J .				00.00
90. 00 09000 CLINI C			1			90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER				0	0	90. 01
90. 02 09002 WOUND CARE CENTER					0	90. 02
90. 03 09003 PAIN CLINIC					0	90. 03
90. 05 09005 0P PSYCH CLINIC 91. 00 09100 EMERGENCY				0	0	90.05
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			7		0	91.00
OTHER REIMBURSABLE COST CENTERS		<u> </u>)	U	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S				0	0	94.00
95. 00 09500 AMBULANCE SERVI CES		1	1]	l	95.00
200.00 Total (lines 50 through 199)				0	474, 333	
	1	-1	1	-1 9	, 555	1-30.00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 |
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

					0 12/31/2018	5/28/2019 12:	
			Title	XVIII	Hospi tal	PPS	07 piii
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			,	and 4)		,	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(201, 032, 079	0.000000	50.00
50. 01	05001 CV SURGERY	0	0	(0	0.000000	50. 01
51.00	05100 RECOVERY ROOM	0	0		31, 313, 685	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(39, 561, 676	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(45, 108, 582	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		98, 962, 524	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	(0	0.000000	56.00
57.00	05700 CT SCAN	0	0	(26, 814, 322	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(8, 859, 864	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(63, 600, 103	0.000000	59. 00
60.00	06000 LABORATORY	0	0	(96, 552, 046	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		14, 580, 246	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		29, 294, 610	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(21, 867, 766	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(14, 217, 782	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(75, 657, 223	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(117, 439, 983	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	474, 333	474, 333	176, 318, 541	0. 002690	73. 00
73. 01	07302 OP PHARMACY	0	0	(0	0.000000	73. 01
74.00	07400 RENAL DIALYSIS	0	0	(4, 654, 015	0.000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(0	0.000000	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0	0.000000	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(3, 093, 904	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0			0.000000	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0	(17, 518, 614	0. 000000	90. 01
90. 02	09002 WOUND CARE CENTER	0	0	(6, 333, 926	0. 000000	90. 02
90. 03	09003 PAIN CLINIC	0	0	(2, 902, 592	0. 000000	
90. 05	09005 OP PSYCH CLINIC	0	0	(2, 493, 323	0. 000000	90. 05
91. 00	09100 EMERGENCY	0	0	(0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(30, 821, 567	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	(0	0. 000000	
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	474, 333	474, 333	3 1, 329, 319, 449		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2018 THROUGH COSTS Part IV 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 x col. 10) 7) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0.000000 36, 564, 585 29, 684, 878 50.00 0 0 50.01 05001 CV SURGERY 0.000000 0 50.01 05100 RECOVERY ROOM 0.000000 4, 176, 548 0 5, 370, 407 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 9, 914 52.00 52.00 120, 822 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 8,079,223 0 8, 820, 856 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 2, 468, 306 41, 302, 086 0 55.00 05600 RADI OI SOTOPE 0.000000 0 56 00 0 56 00 0 05700 CT SCAN 57.00 0.000000 4, 652, 984 5, 120, 766 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 1,060,623 1, 474, 413 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 8, 921, 096 16, 674, 665 0 59.00 06000 LABORATORY 0 0.000000 60 00 60 00 17, 346, 642 7, 193, 777 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 5, 858, 331 65.00 0.000000 755, 145 0 65.00 06600 PHYSI CAL THERAPY 262, 178 66 00 0.000000 4, 250, 663 0 66 00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000000 6,089,066 3, 945, 056 0 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 356, 877 0 70 00 0.000000 3, 372, 288 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 11, 912, 223 0 18, 057, 913 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 33, 656, 120 17, 491, 120 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.002690 31, 819, 237 85, 594 41, 082, 637 110, 512 73.00 07302 OP PHARMACY 0.000000 0 73.01 73.01 0 0 07400 RENAL DIALYSIS 0 74.00 0.000000 2, 412, 646 140, 406 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 0.000000 0 75.01 07697 CARDIAC REHABILITATION 0 0.000000 199, 900 76.97 1, 108, 645 0 76.97 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90 00 0.000000 10, 370 1, 248, 674 0 90.01 09001 OP ONCOLOGY INFUSION CENTER 0.000000 0 6, 698, 092 0 90.01 928, 304 0 09002 WOUND CARE CENTER 90 02 90 02 0.000000 5, 424 1, 694, 931 0 09003 PAIN CLINIC 0.000000 291 1, 096, 168 90.03 90.03 0 09005 OP PSYCH CLINIC 0 90.05 0.000000 3, 807 423, 736 0 90.05

0.000000

0.000000

0.000000

21, 238, 250

204, 619, 539

1, 487, 201

0

0

85, 594

33, 168, 707

12, 219, 231

258, 416, 689

91.00

95 00

0

0 92.00

0 94.00

110, 512 200. 00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

91.00

92.00

94.00

200.00

Cost Center Description	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O HEALTH BLOOMI			Peri od:	Worksheet D	2552-10
Title XVIII Hospital Fox	ALTORITONIMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Trovider C	CIV. 13-0031			
Title XVIII Hospital Promotion Cost to Charge Promotion Cost to Charge Promotion Cost to Charge Promotion Promotion Cost to Charge Promotion Promoti					To 12/31/2018		pared:
Cost Center Description			T' 11	2071.1.1			09 pm
Cost Cost Cost Cost Cost Cost Cost Ratio From Worksheet C. Part 1, cot 9 Services Services Services Services Services Services Services Subject To Subject			li ti e		Hospi tal		
Ratio From		0 1 1 01	DDC D : 1		1 0 1		
MOLILLARY SERVICE COST CENTERS	Cost Center Description						
ANCILLARY SERVICE COST CENTERS						(See Trist.)	
Ded. & Colns. Case Inst.							
NCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Part I, Cor. 9		1			
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS		1 00	2 00			5.00	
50.00	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.01 50.01 CV SURGERY 0.000000 0 0 0 0 50.01		0. 095098	29, 684, 878	3	0 0	2, 822, 973	50.00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0.190429 5,370,407 0 0 1,022,681 51.00 53.00 05200 DELIVERY ROOM & LABOR ROOM 0.200080 0 0 0 0 53.00 53.00 05300 DELIVERY ROOM & LABOR ROOM 0.200080 0 0 0 0 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTIC 0.152553 8,820,856 0 0 1,345,648 54.00 55.00 05400 RADI OLOGY-THERAPEUTIC 0.065279 41,302,086 0 0 2,696,159 55.00 55.00 05600 RADI OLOGY-THERAPEUTIC 0.065279 41,302,086 0 0 2,696,159 55.00 55.00 05600 RADI OLOGY-THERAPEUTIC 0.005000 0 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTIC 0.005000 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTIC 0.005000 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTIC 0.005000 0 0 0 55.00 05600 CARDI AC CATHETERI ZATI ON 0.005000 0 0 0 55.00 05800 CARDI AC CATHETERI ZATI ON 0.045891 1,474,413 0 0 128,246 55.00 60.00 06600 LABORATORY 0.156380 7,193,777 0 0 1,124,819 60.00 60.00 06400 LABORATORY 0.000000 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0.279789 755,145 0 0 211,281 65.00 66.00 06600 PHYSI CAL THERAPY 0.408417 262,178 0 0 107,078 66.00 66.00 06600 PHYSI CAL THERAPY 0.408417 262,178 0 0 107,078 66.00 66.00 06600 PHYSI CAL THERAPY 0.408417 262,178 0 0 107,078 66.00 66.00 06600 PHYSI CAL THERAPY 0.408417 262,178 0 0 0 0 0 0 67.00 0700 0700 0700 0700 0700 0700 0700 67.00 0700 0700 0700 0700 0700 0700 0		1				0	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0. 2000080 9, 914 0 0 1,984 52.00 0530 05300 ARSTHESI LOGY 0. 0000000 0 0 0 0 53.00 05300 ARSTHESI LOGY 0. 0000000 0 0 0 0 0 55.00 05500 ARDI OLOGY-THERAPEUTI C 0. 152553 8,820,856 0 0 2,696,159 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 065279 41,302,086 0 0 2,696,159 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 0 0			 	,		1, 022, 681	1
53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 0 53.00				1			
54.00 05400 RADI OLOGY-DI AGNOSTIC 0. 152553 8, 820, 856 0 0 1. 345, 648 54.00							
55.00 05500 ADDI OLOGY-THERAPEUTIC 0.065279 41, 302, 086 0 0 2, 696, 159 55.00 05.00 05600 ADDI OLOGY-THERAPEUTIC 0.000000 0 0 0 0 0 05.00 05500 ADDI OSTOTPE 0.000000 0 0 0 0 0 057.00 05700 CT SCAN 0.05043 5, 120, 766 0 0 258, 307 57.00 058.00 05900 CARDI AC CATHETERI ZATI ON 0.045891 1, 474, 413 0 0 128, 246 58.00 06.00 06000 LABORATORY 0.000000 0 0 0 0 0 0 0		1	1			1 345 648	•
56. 00 05-00 RADIO I SOTOPE 0.000000 0 0 5.50. 00 5.70. 00 5.					-	.,	
57.00 05700 CT SCAN 0.050413 5.120,766 0 0.288,307 57.00 57.00 57.00 57.00 58.		1				2,070,107	•
58. 00 OSBOO MAGNETIC RESONANCE I MAGING (MRI)		1	1			258 307	•
59.00 CARDI AC CATHETERI ZATION 0.045891 16,674,665 0 0 7.55,217 59.00		•		•			1
60. 00 06000 LABORATORY 0. 156360 7, 193, 777 0 0 1, 124, 819 60. 00 64. 00 06400 INTRAVENOUS THERAPY 0. 000000 0 0 0 0 0 0 0		•		1			
64. 00 06400 INTRAVENOUS THERAPY 0. 000000 0 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 0. 279789 755, 145 0 0 0 11, 281 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 408417 262, 178 0 0 0 0 0 0 0 67. 00 06700 06CUPATI ONAL THERAPY 0. 408417 262, 178 0 0 0 0 0 0 0 68. 00 06800 SPECEH PATHOLOGY 0. 000000 0 0 0 0 0 0 0							
65.00 06500 RESPI RATORY THERAPY 0.279789 755, 145 0 0 211, 281 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 0 0 0 0 0 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 0 0 0 0 0 67.00 68.00 06800 DEECR PATHOLOGY 0.000000 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.78703 3,945,056 0 0 0 439,122 70.00 07000 ELECTROENCEPHALOGRAPHY 0.130215 3,372,288 0 0 439,122 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.199017 18,057,913 0 0 3,593,832 71.00 73.01 07300 DRUGS CHARGED TO PATI ENTS 0.199017 18,057,913 0 0 3,967,091 72.00 73.01 07302 DP PHARIMACY 0.000000 0 0 0 0 0 73.01 73.01 07302 DP PHARIMACY 0.000000 0 0 0 0 0 75.01 07500 ASC (NON-DISTI NCT PART) 0.000000 0 0 0 0 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 461,579 76.97 000000 CLI NI C 0.000000 0 0 0 0 0 75.01 07697 CARDI AC REHABI LITATI ON 0.416345 1,108,645 0 0 461,579 76.97 000000 0 0 0 0 0 0 76.01 09000 CLI NI C 0.00000 0 0 0 0 76.02 09000 CLI NI C 0.00000 0 0 0 0 76.03 09000 CLI NI C 0.00000 0 0 0 0 76.04 09001 0 0 0 0 0 76.05 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 0 76.07 09000 0 0 0 0 76.08 09000 0 0 0 0 0 76.09 09000 0 0 0 0 0 76.00 09000 0 0 0 0 0 76.00 09000 0 0 0 0 76.00 09000 0 0 0 0 76.00 09000 0 0 0 0 76.00 09000 0 0 0 0 76.00 09000 0 0 0 0 76.00 09000 0 0 0 0 76.00 09000 0 0		1				1	•
66. 00 06600 PHYSI CAL THERAPY 0. 408417 262, 178 0 0 107, 078 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 0000000 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 0000000 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 078703 3, 945, 056 0 0 310, 488 89. 00 71. 00 07000 ELECTROCARDI OLOGY 0. 130215 3, 372, 288 0 0 0 439, 122 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 199017 18, 057, 913 0 0 3, 593, 832 71. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 199017 18, 057, 913 0 0 3, 967, 091 72. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 1993855 41, 082, 637 0 160, 174 7, 964, 075 73. 00 71. 01 07300 DRUGS CHARGED TO PATIENTS 0. 193855 41, 082, 637 0 160, 174 7, 964, 075 73. 00 71. 00 07400 RENAL DI ALYSI S 0. 336916 140, 406 0 0 0 0 0 75. 01 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 0 0 0 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 0 76. 97 07500 AGC RERABBL ILITATI ON 0. 416345 1, 108, 645 0 0 461, 579 79. 00 09000 0900					-	1	1
67. 00 06700 05CUPATI ONAL THERAPY 0.000000 0 0 0 0 0 0 67. 00 68. 00 06800 O6800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.078703 3,945,056 0 0 310,488 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.130215 3,372,288 0 0 439,122 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.199017 18,057,913 0 0 3,593,823 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.199017 18,057,913 0 0 3,967,091 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.199365 41,082,637 0 160,174 7,964,075 73. 00 73. 01 07302 DP PHARMACY 0.000000 0 0 0 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 0.336916 140,406 0 0 47,305 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABILITATI ON 0.416345 1,108,645 0 0 461,579 79. 00 09000 CLINI C 0.946836 1,248,674 0 49 1,182,289 90. 00 790. 01 09001 OP ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 328,173 790. 03 09003 PAIN CLINIC 0.19856 0.198620 1,694,931 0 0 328,173 790. 05 09005 OP PSYCH CLINIC 0.193620 1,694,931 0 0 328,173 791. 00 09000 OP ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 328,173 791. 00 09000 OP ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 328,173 791. 00 09000 OP ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 0 2,13,366 791. 00 09000 OP ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 0 2,13,366 791. 00 09000 OP ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 0 0 0 791. 00 09000 OF ONCOLOGY INFUSION CENTER 0.193620 1,694,931 0 0 0 0 0 791. 00 09000 OF ONCOLOGY INFUSION CENTER 0.193620 0 0 0 0 0 0 791. 00 09000 OF ONCOLOGY INFUSION CENTER 0.193620 0 0 0 0 0 0 0 791. 00 09000 09000							
68. 00		1					
69. 00 06900 ELECTROCARDI OLOGY 0. 078703 3, 945, 056 0 0 310, 488 69. 00 070.00 07000 ELECTROENCEPHALOGRAPHY 0. 130215 3, 372, 288 0 0 439, 122 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 199017 18, 057, 913 0 0 3, 593, 832 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 199365 41, 082, 637 0 160, 174 7, 964, 075 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 193855 41, 082, 637 0 160, 174 7, 964, 075 73. 01 07302 DP PHARMACY 0. 000000 0 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0. 336916 140, 406 0 0 0 0 0 0 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 0 0 0 0 0		•	l l				
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 130215 3. 372, 288 0 0 439, 122 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 199017 18, 057, 913 0 0 3, 967, 9091 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193855 41, 082, 637 0 160, 174 7, 964, 075 73. 00 73. 01 07302 07400 RANAL DI ALYSI S 0. 336916 140, 406 0 0 47, 305 74. 00 7		1				310. 488	
71. 00					0 0		
72. 00 07200 IMPL DEV CHARGED TO PATIENTS 0. 226806 17, 491, 120 0 0 3, 967, 091 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193855 41, 082, 637 0 160, 174 7, 964, 075 73. 00 07302 0P PHARMACY 0. 0000000 0 0 0 0 0 0		1			0 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 193855 41, 082, 637 0 160, 174 7, 964, 075 73. 00 73. 01 07302 OP PHARMACY 0. 0000000 0 0 0 0 0 0					0 0		
73. 01 07302 OP PHARMACY O. 000000 O O O O O 73. 01 74. 00 07400 RENAL DIALYSIS O. 336916 140, 406 O O 0 47, 305 75. 00 07500 ASC (NON-DISTINCT PART) O. 000000 O O O O O 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O. 000000 O O O O 76. 97 O7697 CARDI AC REHABI LITATI ON O. 416345 1, 108, 645 O O 461, 579 90. 00 09900 CLI NI C O. 946836 1, 248, 674 O 49 1, 182, 289 90. 01 099001 OP ONCOLOGY I NIFUSI ON CENTER O. 267758 6, 698, 092 O O 1, 793, 468 90. 01 90. 02 099002 WOUND CARE CENTER O. 193620 1, 694, 931 O O 328, 173 90. 02 90. 03 09003 PAI N CLI NI C O. 199546 1, 096, 168 O O 218, 736 90. 03 90. 05 09005 OP PSYCH CLI NI C O. 199546 1, 096, 168 O O 218, 736 90. 03 90. 05 09005 OP PSYCH CLI NI C O. 183113 12, 219, 231 296 O 2, 213, 062 92. 00 09200 DSERVATI ON BEDS (NON-DISTINCT PART) O. 181113 12, 219, 231 296 O 2, 213, 062 94. 00 09400 HOME PROGRAM DI ALYSI S O. 000000 O. 001 V. Charges O. 001					0 160, 174		
75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 75. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 75. 01 76. 97 07697 CARDI AC REHABILI TATI ON 0.416345 1,108,645 0 0 461,579 90. 00 09000 CLI NI C 0.946836 1,248,674 0 49 1,182,289 90. 01 09001 0P ONCOLOGY I NFUSI ON CENTER 0.267758 6,698,092 0 0 1,793,468 90. 01 90. 02 09002 WOUND CARE CENTER 0.193620 1,694,931 0 0 328,173 90. 02 90. 03 09003 PAIN CLI NI C 0.199546 1,096,168 0 0 218,736 90. 03 90. 05 09005 0P PSYCH CLI NI C 1.334734 423,736 619 0 565,575 90. 00 09100 EMERGENCY 0.066320 33,168,707 0 30 2,199,749 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.181113 12,219,231 296 0 2,213,062 92. 00 09400 HOME PROGRAM DI ALYSI S 0.000000 93. 00 09500 AMBULANCE SERVI CES 0.218618 0 94. 00 09100 Less PBP Cli ni c Lab. Servi ces-Program 0 0 0 90. 01 07500	73. 01 07302 OP PHARMACY	0. 000000			0 0	0	73. 01
75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 75. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 75. 01 76. 97 07697 CARDI AC REHABILI TATI ON 0.416345 1,108,645 0 0 461,579 90. 00 09000 CLI NI C 0.946836 1,248,674 0 49 1,182,289 90. 01 09001 0P ONCOLOGY I NFUSI ON CENTER 0.267758 6,698,092 0 0 1,793,468 90. 01 90. 02 09002 WOUND CARE CENTER 0.193620 1,694,931 0 0 328,173 90. 02 90. 03 09003 PAIN CLI NI C 0.199546 1,096,168 0 0 218,736 90. 03 90. 05 09005 0P PSYCH CLI NI C 1.334734 423,736 619 0 565,575 90. 00 09100 EMERGENCY 0.066320 33,168,707 0 30 2,199,749 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.181113 12,219,231 296 0 2,213,062 92. 00 09400 HOME PROGRAM DI ALYSI S 0.000000 93. 00 09500 AMBULANCE SERVI CES 0.218618 0 94. 00 09100 Less PBP Cli ni c Lab. Servi ces-Program 0 0 0 90. 01 07500	74. 00 07400 RENAL DIALYSIS	0. 336916	140, 406	,	0 0	47, 305	74.00
76. 97	75.00 07500 ASC (NON-DISTINCT PART)				0 0	0	75. 00
OUTPATI ENT SERVICE COST CENTERS 90.00 O9000 CLINI C O.946836 1, 248, 674 O 49 1, 182, 289 90.00 90.01 O9001 OP ONCOLOGY INFUSION CENTER O.267758 6, 698, 092 O O 1, 793, 468 90.01 O9002 WOUND CARE CENTER O.193620 1, 694, 931 O O 328, 173 O0.02 O9003 PAIN CLINI C O.199546 1, 096, 168 O O 218, 736 O0.03 O9005 OP PSYCH CLINI C 1. 334734 423, 736 619 O 565, 575 O0.05 O9005 OP PSYCH CLINI C O.066320 33, 168, 707 O 30 2, 199, 749 91.00 O9100 EMERGENCY O.066320 33, 168, 707 O 30 2, 199, 749 91.00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) O.181113 12, 219, 231 296 O 2, 213, 062 O2.00 O9500 AMBULANCE SERVI CES O.218618 O O.218618 O O9500 Constant of the constant	75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	75. 01
OUTPATI ENT SERVICE COST CENTERS 90.00 O9000 CLINI C O.946836 1, 248, 674 O 49 1, 182, 289 90.00 90.01 O9001 OP ONCOLOGY INFUSION CENTER O.267758 6, 698, 092 O O 1, 793, 468 90.01 O9002 WOUND CARE CENTER O.193620 1, 694, 931 O O 328, 173 O0.02 O9002 O9003 PAIN CLINI C O.199546 1, 096, 168 O O 218, 736 O0.03 O9005 OP PSYCH CLINI C 1. 334734 423, 736 619 O 565, 575 O0.05 O9005 OP PSYCH CLINI C O.066320 33, 168, 707 O 30 2, 199, 749 O.066320 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) O.181113 12, 219, 231 296 O 2, 213, 062 O2.00 O9500 AMBULANCE SERVI CES O.218618 O O9500 O9500 AMBULANCE SERVI CES O.218618 O O19 O19 O0 O19	76. 97 07697 CARDIAC REHABILITATION	0. 416345	1, 108, 645	i	0 0	461, 579	76. 97
90. 01 09001 09001 09 0000 000000	OUTPATIENT SERVICE COST CENTERS						
90. 02 09002 WOUND CARE CENTER 0. 193620 1, 694, 931 0 0 328, 173 90. 02 90. 03 90. 03 90. 03 PAIN CLINIC 0. 199546 1, 096, 168 0 0 218, 736 90. 03 90. 05 09005 0P PSYCH CLINIC 1. 334734 423, 736 619 0 565, 575 90. 05 91. 00 09100 EMERGENCY 0. 066320 33, 168, 707 0 30 2, 199, 749 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 181113 12, 219, 231 296 0 2, 213, 062 92. 00 09200		0. 946836	1, 248, 674			1, 182, 289	90.00
90. 03	90. 01 09001 OP ONCOLOGY INFUSION CENTER	0. 267758	6, 698, 092	2	0	1, 793, 468	90. 01
90. 05 09005 09 PSYCH CLINIC 1. 334734 423,736 619 0 565,575 90. 05 91. 00 09100 EMERGENCY 0. 066320 33, 168,707 0 30 2, 199,749 91. 00 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 0. 181113 12, 219, 231 296 0 2, 213, 062 92. 00 07 0 07 0 0 0 0 0	90. 02 09002 WOUND CARE CENTER	0. 193620	1, 694, 931		0	328, 173	90. 02
91. 00 09100 EMERGENCY 0. 066320 33, 168, 707 0 30 2, 199, 749 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 181113 12, 219, 231 296 0 2, 213, 062 92. 00 OTHER REI MBURSABLE COST CENTERS 0. 000000 0. 2 0. 000000 95. 00 09500 AMBULANCE SERVICES 0. 218618 0 200. 00 Subtotal (see instructions) 258, 416, 689 915 160, 253 35, 768, 937 200. 00 201. 00 Cess PBP Clinic Lab. Services-Program 0 0 0 00 00 00 00 00	90. 03 09003 PAIN CLINIC	0. 199546	1, 096, 168	3	0	218, 736	90. 03
92. 00	90. 05 09005 OP PSYCH CLINIC	1. 334734	423, 736	61	9 0	565, 575	90. 05
OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS O.000000 O9500	91. 00 09100 EMERGENCY	0. 066320	33, 168, 707	'	0 30	2, 199, 749	91.00
94. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 181113	12, 219, 231	29	0	2, 213, 062	92. 00
95. 00							
200.00 Subtotal (see instructions) 258,416,689 915 160,253 35,768,937 200.00					-		
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges		0. 218618	l l		9		95. 00
Only Charges			258, 416, 689	91	1		
					0		201.00
202. 00			250 417 722		1/0 050	25 7/0 007	202 00
	202.00 Net charges (Time 200 - Time 201)	1	258, 416, 689	'I 91	150, 253	35, /68, 93/	J202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2018 Part V
To 12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm Provider CCN: 15-0051

						5/28/2019 12:	09 pm
			Title	XVIII	Hospi tal	PPS	
		Cost	S				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
			Services Not				
		Subject To	Subject To				
			ed. & Coins.				
		(see inst.)	(see inst.)				
	ANCILL ADV. CEDVI CE. COCT. CENTEDO	6.00	7. 00				
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0				50.00
50. 00	05001 CV SURGERY		0				50. 00
51. 00	05100 RECOVERY ROOM		0				51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0				52.00
53. 00	05300 ANESTHESI OLOGY		0				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0				55. 00
56. 00	05600 RADI OLOGI - THERAI EUTT C		0				56.00
57. 00	05700 CT SCAN		0				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0				59. 00
60.00	06000 LABORATORY		0				60.00
64. 00	06400 I NTRAVENOUS THERAPY		0				64. 00
65. 00	06500 RESPIRATORY THERAPY		0				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	o				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	l ol	o				67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	o				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	O				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	31, 051				73. 00
73. 01	07302 OP PHARMACY	0	0				73. 01
74.00	07400 RENAL DIALYSIS	0	0				74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	46				90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0				90. 01
90. 02	09002 WOUND CARE CENTER	0	0				90. 02
90. 03	09003 PAIN CLINIC	0	0				90. 03
90. 05	09005 OP PSYCH CLINIC	826	0				90. 05
91. 00	09100 EMERGENCY	0	2				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	54	0				92. 00
04.00	OTHER REIMBURSABLE COST CENTERS						04.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 200. 00	09500 AMBULANCE SERVICES	0 880	31, 099				95. 00 200. 00
200.00	,	880	31,099				200.00
201.00	Only Charges						201.00
202.00		880	31, 099				202. 00
202.00	, sharges (11110 200 11110 201)	300	31, 377				1-52. 00

Component CR: 15-T05 From 01/01/2018 Bater/Time Prepare To 12/31/2018 Bater/T	Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	J HEALTH BLOOMI	NGTON HOSPITAL Provider C		In Lie Period:	u of Form CMS-: Worksheet D	2552-10
Capit al Related Cost Cfrom Wisst. Color Cost Co	ANTONINE IN OF THE ATTEMPT AND TELL IN SERVICE GATTE	00010		F	rom 01/01/2018	Part II Date/Time Pre	pared: 09 pm
Capit al Related Cost (From Wisst. B. Part III, col. 26) Capit al Related Cost (From Wisst. C. Part II, col. 26) Capit al Cost (From Wisst. C. Part II, col. 26) Capit al Cost (Col. 1 + col. 26) Capit al Cost (Col. 26) Capit al Cos			Title	e XVIII			
ANCILLARY SERVICE COST CENTERS Part II, col 20,	Cost Center Description				I npati ent		
Part II							
ANCILLARY SERVICE COST CENTERS					charges	COLUMN 4)	
ANCILLARY SERVICE COST CENTERS			0)	2)			
SO.00 050000 05000 050000 050000 050000 050000 050000 0500000 0500000 0500000 0500000 05000000 050000000 0500000000			2.00	3.00	4. 00	5. 00	
SO.01 OSOO1 CV SURGERY O	ANCILLARY SERVICE COST CENTERS			•			
55.00 05500 RECOVERY ROOM 175, 361 31, 313, 381, 805 0.005600 0 0 52 53.00 05200 DELIVERY ROOM & LABOR ROOM 861, 744 39, 561, 676 0.021782 0 0.000000 0 0.53 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 0 0.000000 0		1, 429, 068	201, 032, 079	0. 007109	23, 180	165	50. 00
52.00 05.200 05		0	0	0. 000000	0	0	50. 01
53.00 05.00 05.00 AMESTHESI OLOGY 0 0 0 0 0.000000 0 0 53		1		1		_	51. 00
54.00 05400 RADI OLOGY-DI AGNOSTIC 546, 0.61 45, 108, 582 0. 012105 39, 328 476 54 55.00 05500 RADI OLOGY-THERAPEUTIC 569, 261 98, 962, 524 0. 005752 9, 411 54 55.00 05600 RADI OLOGY-THERAPEUTIC 569, 261 98, 962, 524 0. 005752 9, 411 54 55.00 05600 RADIO I SOTOPE 0 0 0. 000000 0 0 56 57.00 05500 CT SCAN 46, 869 26, 814, 322 0. 001748 15, 108 26 57 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 52, 646 8, 859, 864 0. 005942 12, 891 77 58 59.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 52, 646 8, 859, 864 0. 005942 12, 891 77 58 59.00 05900 CARDI AC CATHETERI ZATI ON 190, 313 63, 600, 103 0. 002992 0 0 5 64 64.00 0. 000000 0. 000000 0 0. 000000 0		1	39, 561, 676	1			52. 00
55.00 05500 RADI OLOGY-THERAPEUTIC 569, 261 98, 962, 524 0.005752 9, 411 54 55		0	0	1		_	53. 00
56. 00 05600 RADIO I SOTOPE 0							
57. 00 05700 CT SCAN 46,869 26,814,322 0.001748 15,108 26 57		569, 261	98, 962, 524	1			55.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 52, 646 8, 859, 864 0.005942 12, 891 77 58 59.00 05900 CARDIAC CATHETERIZATION 190, 313 63, 600, 103 0.002992 0 0 59 60.00 06000 LABBORATORY 562, 943 96, 552, 046 0.005830 367, 649 2, 143 60 64.00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 0 64 65.00 06500 RESPIRATORY THERAPY 81, 727 14, 580, 246 0.005605 55, 945 314 65 66.00 06600 PHYSI CAL THERAPY 362, 897 29, 294, 610 0.012388 3, 888, 576 48, 172 66 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0.000000 0 0 68 69.00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 0 68 69.00 06900 ELECTROCARDI OLOGY 80, 712 21, 867, 766 0.003691 18, 858 70 69 70.00 07000 ELECTROENCEPHALOGRAPHY 117, 341 14, 217, 782 0.008253 6, 145 51 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 353, 394 117, 439, 983 0.003009 9, 300 28 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 353, 394 117, 439, 983 0.003009 9, 300 28 72 73.01 07302 OP PHARIMACY 0 0 0.000000 0 0 75 75.01 07500 ASC (NON-DI STI NCT PART) 0 0.000000 0 0 75 76.97 07697 CARDIA C REHABI LITATION 100, 188 3,093, 904 0.032382 29, 127 943 76 76.00 07000 CLINIC 0.000000 0 0 0 0 76.00 09000 OP ONCOLOGY INFUSION CENTER 142, 217 17, 518, 614 0.008718 0.0025522 0 0 0 79.01 09001 OP ONCOLOGY INFUSION CENTER 142, 217 17, 518, 614 0.008118 0 0 0 79.00 09000 DRESERRANTION BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004000 37, 771 154 91 79.00 09000 DRESERVATION BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004000 37, 771 154 91 79.00 09400 DRESERRANTION BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004000 37, 771 154 91 79.00 09400 DRESERVATION BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004000 37, 771 154 91 79.00 09400 DRESER		14 940	24 014 222				56. 00 57. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 190, 313 63, 600, 103 0.002992 0 0 0 59	58 OO O58OO MAGNETIC RESONANCE IMAGING (MRI)			1			58.00
60. 00 06000 LABORATORY 562, 943 96, 552, 046 0.005830 367, 649 2, 143 60 64. 00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 0 64 65. 00 06500 RESPI RATORY THERAPY 362, 897 29, 294, 610 0.012388 3, 888, 576 48, 172 66 67. 00 06000 PHYSI CAL THERAPY 0 0 0.000000 0 0 0 67 68. 00 06800 SPEECH PATHOLOGY 0 0.000000 0 0 0 68 69. 00 06900 ELECTROCARDI OLOGY 80, 712 21, 867, 766 0.003691 18, 858 70 69 0.000000 0 0 0 0 0 0 0				1			59.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 0 64 65.00 06500 RESPIRATORY THERAPY 81,727 14,580,246 0.005605 55,945 314 66.00 06600 PHYSI CAL THERAPY 362,897 29,294,610 0.012388 3,888,576 48,172 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0.000000 0 0 68.00 06800 SPECCH PATHOLOGY 0 0.000000 0 0 0 69.00 06900 ELECTROCARPI OLOGY 80,712 21,867,766 0.03691 18,858 70 69.00 06900 ELECTROCARPI OLOGY 80,712 21,867,766 0.03691 18,858 70 71.00 07000 REDI CAL SUPPLIES CHARGED TO PATIENTS 201,797 75,657,223 0.002667 61,520 164 71 72.00 07200 IMPLD DEV. CHARGED TO PATIENTS 201,797 75,657,223 0.002667 61,520 164 71 73.01 07300 DRUGS CHARGED TO PATIENTS 488,577 176,318,541 0.002771 846,100 2,345 73 73.01 07300 DRUGS CHARGED TO PATIENTS 353,394 117,439,983 0.033099 9,300 28 72 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0 0 75 76.97 07697 CARDAL DI ALYSI S 35,028 4,654,015 0.007526 138,426 1,042 74 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0 75 76.97 07697 CARDAL CREHABI LI TATI ON 100,188 3,093,904 0.032382 29,127 943 76 90.01 09000 CLINIC 280,952 2,799,119 0.100372 0 0 90 90.02 09000 DONOLOGY I NFUSI ON CENTER 142,217 17,518,614 0.008118 0 0 90 90.03 09003 PAIN CLINIC 74,080 2,902,592 0.025522 0 0 90 90.04 09000 DRUGRECENTER 121,829 6,333,926 0.019234 0 0 90 90.05 09000 PSYCH CLINIC 308,732 2,493,323 0.123824 0 0 90 91.00 09000 DRUGRECENTY 807,888 197,521,357 0.004090 37,771 154 91 92.00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0 30,821,567 0.000000 21,575 0 94.00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0						_	
66. 00 06600 PHYSI CAL THERAPY 362, 897 29, 294, 610 0.012388 3, 888, 576 48, 172 66 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0 0 67 68. 00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 0 68 69. 00 06900 ELECTROCARDI OLOGY 80, 712 21, 867, 766 0.003691 18, 858 70 69 70. 00 07000 ELECTROENCEPHALOGRAPHY 117, 341 14, 217, 782 0.008253 6, 145 51 70 71. 00 07100 MEDIC CAL SUPPLIES CHARGED TO PATIENTS 201, 797 75, 657, 223 0.002667 61, 520 164 71 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 353, 394 117, 439, 983 0.003009 9, 300 28 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 488, 577 176, 318, 541 0.002771 846, 100 2, 345 73 73. 01 07302 OP PHARMACY 0 0 0.000000 0 0 73 74. 00 07400 RENAL DIALYSIS 35, 028 4, 654, 015 0.007526 138, 426 1, 042 74 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0 0 75 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0 0.000000 0 0 75 76. 97 07697 CARDI AC REHABI LI TATI ON 100, 188 3, 093, 904 0.03282 29, 127 943 76 90. 00 90000 CLINI C 282, 52 2, 799, 119 0.100372 0 0 90 90. 01 09001 OP ONCOLOGY I NFUSI ON CENTER 142, 217 17, 518, 614 0.008118 0 0 90 90. 02 09002 WOUND CARE CENTER 121, 829 6, 333, 926 0.019234 0 0 90 90. 05 09005 OP PSYCH CLINI C 308, 732 2, 493, 323 0.123824 0 0 90 91. 00 99005 OP PSYCH CLINI C 308, 732 2, 493, 323 0.123824 0 0 90 91. 00 99005 OP PSYCH CLINI C 80, 788 197, 521, 357 0.004090 37, 771 154 91 92. 00 09000 DEBEROALY ION BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004090 37, 771 154 91 92. 00 09400 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004090 37, 771 154 91 94. 00 09400 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.004090 37, 771 154 91		0	0				64. 00
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69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 000000	0	0	67. 00
70. 00			·				68. 00
71. 00							
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73. 00 07300 DRUGS CHARGED TO PATIENTS 488, 577 176, 318, 541 0.002771 846, 100 2, 345 73. 01 07302 OP PHARMACY 0 0 0.000000 0 0 0 73. 074. 00 07400 RENAL DI ALYSIS 35,028 4,654,015 0.007526 138, 426 1,042 74. 00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 0 0 0.000000 0 0 0 0				1	·		1
73. 01 07302 OP PHARMACY 0 0 0.000000 0 0.000000 0 73 74. 00 07400 RENAL DI ALYSI S 35,028 4,654,015 0.007526 138,426 1,042 74 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0.000000 0 0 75 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0 0 75 76. 97 07697 CARDI AC REHABI LI TATI ON 100,188 3,093,904 0.032382 29,127 943 76 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 280,952 2,799,119 0.100372 0 0 90 90. 01 09001 0P ONCOLOGY I NFUSI ON CENTER 142,217 17,518,614 0.008118 0 0 90 90. 02 09002 WOUND CARE CENTER 121,829 6,333,926 0.019234 0 0 99 90. 03 09003 PAI N CLI NI C 74,080 2,902,592 0.025522 0 0 0 90 90. 05 09005 OP PSYCH CLI NI C 308,732 2,493,323 0.123824 0 0 99 91. 00 09100 EMERGENCY 807,888 197,521,357 0.004090 37,771 154 91 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 30,821,567 0.000000 21,575 0 92 OTHER REI MBURSABLE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATTENTS			1			
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 07 07697 CARDI AC REHABI LI TATI ON 76. 07 07697 CARDI AC REHABI LI TATI ON 76. 09 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		488, 577	176, 318, 541	l .			73.00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0 0 75. 75. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0 75. 76. 97 07697 CARDI AC REHABI LI TATI ON 100, 188 3, 093, 904 0.032382 29, 127 943 76.		35.028	4 654 015	1			
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0.000000 0 75. 76. 97 07697 CARDI AC REHABI LI TATI ON 100, 188 3, 093, 904 0.032382 29, 127 943 76. OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 280, 952 2, 799, 119 0.100372 0 0 90. 90. 01 09001 0P ONCOLOGY I NFUSI ON CENTER 142, 217 17, 518, 614 0.008118 0 0 90. 90. 02 09002 WOUND CARE CENTER 121, 829 6, 333, 926 0.019234 0 0 90. 90. 03 09003 PAI N CLI NI C 74, 080 2, 902, 592 0.025522 0 0 90. 90. 05 09005 0P PSYCH CLI NI C 308, 732 2, 493, 323 0.123824 0 0 90. 91. 00 09100 EMERGENCY 807, 888 197, 521, 357 0.004090 37, 771 154 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 30, 821, 567 0.000000 21, 575 0 92. OTHER REI MBURSABLE COST CENTERS							
76. 97		0	Ö				75. 01
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 280,952 2,799,119 0.100372 0 0 90. 90.01 09001 0P ONCOLOGY INFUSION CENTER 142,217 17,518,614 0.008118 0 0 90. 90.02 09002 WOUND CARE CENTER 121,829 6,333,926 0.019234 0 0 90. 90.03 09003 PAIN CLINIC 74,080 2,902,592 0.025522 0 0 90. 90.05 09005 OP PSYCH CLINIC 308,732 2,493,323 0.123824 0 0 90. 91.00 09100 EMERGENCY 807,888 197,521,357 0.004090 37,771 154 91. 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 30,821,567 0.000000 21,575 0 92. 0THER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0.000000 0 0 94.		100, 188	3, 093, 904	1		943	
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90. 02 09002 WOUND CARE CENTER 121,829 6,333,926 0.019234 0 0 90.900 90. 03 09003 PAIN CLINIC 74,080 2,902,592 0.025522 0 0 90.900 90. 05 09005 OP PSYCH CLINIC 308,732 2,493,323 0.123824 0 0 90.900 91. 00 09100 EMERGENCY 807,888 197,521,357 0.004090 37,771 154 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 30,821,567 0.000000 21,575 0 92. 00 OFFICE		280, 952	2, 799, 119	0. 100372	2 0	0	90. 00
90. 03 09003 PAIN CLINIC 74,080 2,902,592 0.025522 0 0 90.		142, 217	17, 518, 614	0. 008118	0	0	90. 01
90. 05 09005 0P PSYCH CLINIC 308, 732 2, 493, 323 0. 123824 0 0 90 90 91. 00 09100 EMERGENCY 807, 888 197, 521, 357 0. 004090 37, 771 154 91. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 30, 821, 567 0. 000000 21, 575 0 92. 00 09400 HOME PROGRAM DIALYSIS 0 0 0. 000000 0 0 94.				1		_	
91. 00 09100 EMERGENCY 807, 888 197, 521, 357 0. 004090 37, 771 154 91. 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 30, 821, 567 0. 000000 21, 575 0 92. 00 09400 HOME PROGRAM DIALYSIS 0 0 0. 000000 0 0 94.						_	90. 03
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 30, 821, 567 0.000000 21, 575 0 92 0THER REIMBURSABLE COST CENTERS 0 0 0.000000 0 0 94						_	90. 05
OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0.000000 0 0 94.							91.00
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				0.00000		0	94. 00
				0.00000		0	95.00
200. 00 Total (lines 50 through 199) 7, 991, 625 1, 329, 319, 449 5, 580, 910 56, 224 200.	· · · · · · · · · · · · · · · · · · ·	7, 991, 625	1, 329, 319, 449		5, 580, 910	56. 224	

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051	Peri od: From 01/01/2018	Worksheet D Part IV
		Component CCN: 15-T051	To 12/31/2018	Date/Time Prepared: 5/28/2019 12:09 pm
		T: +1 - \/\/1 1	Code and a state of	DDC

						3/20/2019 12.	U7 PIII
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown		Post-Stepdown	Airred hearth	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	J.	3.00	
50.00	05000 OPERATI NG ROOM				0	0	50.00
50. 01	05001 CV SURGERY				0 0	Ô	50. 01
51. 00	05100 RECOVERY ROOM					o o	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM					,	52.00
53. 00	05300 ANESTHESI OLOGY					Ö	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					,	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C					,	55. 00
56. 00	05600 RADI OI SOTOPE					,	56.00
57. 00	05700 CT SCAN					,	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)					,	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON					,	59.00
60.00	06000 LABORATORY					,	60.00
64. 00	06400 I NTRAVENOUS THERAPY					,	64.00
65. 00	06500 RESPIRATORY THERAPY					0	65.00
66. 00	06600 PHYSI CAL THERAPY					o o	66.00
67. 00	06700 OCCUPATI ONAL THERAPY					0	67.00
68. 00	06800 SPEECH PATHOLOGY					,	68. 00
	06900 ELECTROCARDI OLOGY				0	o o	69.00
	07000 ELECTROENCEPHALOGRAPHY					0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS				0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS				0	474, 333	73. 00
73. 01	07302 OP PHARMACY				0	0	1
74.00	07400 RENAL DI ALYSI S	C			0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)) c		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C) c		0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON) (0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	(C)) (0	0	90.00
	09001 OP ONCOLOGY INFUSION CENTER	C) c		0	0	90. 01
90. 02	09002 WOUND CARE CENTER	C) c		0	0	90. 02
90. 03	09003 PAIN CLINIC	C) c		0	0	90. 03
	09005 OP PSYCH CLINIC	C) c		0	0	90. 05
91. 00	09100 EMERGENCY	C) () (0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C)	(0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	C	0) (0	0	94. 00
95.00	09500 AMBULANCE SERVICES	_	_		_		95. 00
200.00	Total (lines 50 through 199)	() C) (0	474, 333	J200. 00

Heal th	n Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL	<u>-</u>	In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROU	GH COSTS		Component		From 01/01/2018 To 12/31/2018		pared:
						5/28/2019 12:0	09 pm
			litle	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3, and 4)	8)	7)	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00		0	O)	0 201, 032, 079	0.000000	
50. 01	05001 CV SURGERY	0	0		0	0.000000	50. 01
51. 00		0	0		0 31, 313, 685	0.000000	
52.00		0	0		0 39, 561, 676		
53.00		0	0		0	0. 000000	
54. 00		0	0		0 45, 108, 582		
55. 00		0	0		98, 962, 524		
56. 00		0	0		0 0	0. 000000	
57. 00		0	0		0 26, 814, 322		
58. 00		0	0)	0 8, 859, 864		
59. 00		0	0)	0 63, 600, 103		
60.00		0	U)	96, 552, 046		
64.00		0	U	,	0 14 500 244	0.000000	
65. 00 66. 00		0	0		0 14, 580, 246 0 29, 294, 610		
67. 00		0	0		29, 294, 010	0.000000	
68. 00		0	0			0.000000	
69. 00		0	0		0 21, 867, 766		
70. 00		0	0		0 14, 217, 782		
71. 00		0	0		0 75, 657, 223		
72. 00		0	Ö		0 117, 439, 983		
73. 00		0	474, 333	474, 33		0. 002690	
73. 01	07302 OP PHARMACY	0	, 555	, 55	0 0	0. 000000	
74. 00		0	Ö		0 4, 654, 015		
75. 00		0	O		0 0	0. 000000	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	O		0	0.000000	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 3, 093, 904	0. 000000	76. 97
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17, 518, 614

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2, 493, 323

197, 521, 357

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09000 CLI NI C

90. 02 09002 WOUND CARE CENTER

09003 PAIN CLINIC

94.00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

90.05 09005 OP PSYCH CLINIC

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

09001 OP ONCOLOGY INFUSION CENTER

OTHER REIMBURSABLE COST CENTERS

90.00

90.01

90.03

91.00

92.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

		U HEALTH BLOOMIN		ON 45 0054		u of Form CMS-2	2552-10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider CO	JN: 15-0051	Peri od: From 01/01/2018	Worksheet D Part IV	
THROUGH	COSTS		Component (CCN: 15-T051	To 12/31/2018		
			Title	XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
Α	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	0. 000000	23, 180		0 0	0	50.00
50. 01 0	5001 CV SURGERY	0. 000000	0		0 0	0	50. 01
51.00 0	5100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
	5300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	39, 328		0	0	
	5500 RADI OLOGY-THERAPEUTI C	0. 000000	9, 411		0 0	0	55. 00
	5600 RADI OI SOTOPE	0. 000000	2, 111		0 0	Ö	
	5700 CT SCAN	0. 000000	15, 108		0 0	0	
	15800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	12, 891		0 0	0	58.00
	15900 CARDI AC CATHETERI ZATI ON	0.000000	12, 091		0 0	0	
	16000 LABORATORY	0. 000000	· ·		0 0	0	
	16400 INTRAVENOUS THERAPY	0. 000000	367, 649 0		0 0	0	
			O		-		64.00
	6500 RESPI RATORY THERAPY	0.000000	55, 945			0	
	16600 PHYSI CAL THERAPY	0.000000	3, 888, 576		0	0	
	6700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
	6800 SPEECH PATHOLOGY	0. 000000	0		0	0	
	6900 ELECTROCARDI OLOGY	0. 000000	18, 858		0	0	
	7000 ELECTROENCEPHALOGRAPHY	0. 000000	6, 145		0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	61, 520		0	0	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	9, 300		0	0	
	7300 DRUGS CHARGED TO PATIENTS	0. 002690	846, 100	2, 27		0	
73. 01 0	7302 OP PHARMACY	0. 000000	0		0	0	73. 01
	7400 RENAL DIALYSIS	0. 000000	138, 426		0	0	
	7500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
75. 01 0	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	75. 01
76. 97 0	7697 CARDIAC REHABILITATION	0. 000000	29, 127		0 0	0	76. 97
0	UTPATIENT SERVICE COST CENTERS	·					1
90.00 0	9000 CLI NI C	0. 000000	0		0 0	0	90.00
90.01 0	19001 OP ONCOLOGY INFUSION CENTER	0. 000000	0		0 0	0	90. 01
	19002 WOUND CARE CENTER	0. 000000	0		0 0	0	90. 02
	9003 PAIN CLINIC	0. 000000	0		0 0	0	
	19005 OP PSYCH CLINIC	0. 000000	0		0 0	0	
	9100 EMERGENCY	0. 000000	37, 771		0 0	0	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	21, 575		0 0	0	
	THER REIMBURSABLE COST CENTERS	0.000000	21, 373		0	0	72.00
	19400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
	19500 AMBULANCE SERVICES	0.000000	U			U	95.00
70. UU U		1		l			
200.00	Total (lines 50 through 199)	1	5, 580, 910	2, 27	6 0	^	200.00

					5/28/2019 12:	09 pm
		Titl∈	e XVIII	Subprovi der - I RF	PPS	
			Charges	INI	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	,	Cost	PPS Services	
	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	.1			
50. 00 05000 OPERATI NG ROOM	0. 095098				0	
50. 01 05001 CV SURGERY	0.000000	l .			0	00.0.
51. 00 05100 RECOVERY ROOM	0. 190429	l .			0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 200080	l .		-	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	l .		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 152553	l .			0	54.00
	0. 065279		1	-	0	
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0. 000000 0. 050443	l .			0	56. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 086981				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 045891				0	59.00
60. 00 06000 LABORATORY	0. 156360	_			0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	_	1		0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 279789	l .			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 408417		l .		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000		l .		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 078703	l .	1		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 130215		1		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199017		l		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 226806		l		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 193855		•		0	73. 00
73. 01 07302 OP PHARMACY	0. 000000				0	73. 01
74.00 07400 RENAL DIALYSIS	0. 336916	d		0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	O		0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	0. 416345	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 946836			0	0	
90.01 09001 OP ONCOLOGY INFUSION CENTER	0. 267758	l .			0	
90. 02 09002 WOUND CARE CENTER	0. 193620	l .			0	90. 02
90. 03 09003 PAIN CLINIC	0. 199546	l .	•		0	90. 03
90. 05 09005 OP PSYCH CLINIC	1. 334734	l .	1	-	0	90. 05
91. 00 09100 EMERGENCY	0. 066320		1		0	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 181113	0) (0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		T				
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000					94. 00
95. 00 09500 AMBULANCE SERVICES	0. 218618				_	95. 00
200.00 Subtotal (see instructions)		0	1		0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 ال		201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)			,	203	0	202. 00
202.00 Net Charges (Title 200 - Title 201)	I	1	'I	203	0	1202.00

Health Financial Systems	IU HEALTH BLOOMIN				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE	COST		CN: 15-0051 CCN: 15-T051	Peri od: From 01/01/2018 To 12/31/2018		pared:
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	•
Cost Center Description		Costs			•		
		t	Cost				

				I RF	
		Cos	sts		
	Cost Center Description	Cost	Cost		
	·	Rei mbursed	Reimbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
			Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS	0.00	7.00		
50. 00	05000 OPERATING ROOM	0	0		50.00
50. 00	05001 CV SURGERY	0			50. 00
51. 00	05100 RECOVERY ROOM		0		51. 00
	1	0	1	1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	l control of the cont	55. 00
56. 00	05600 RADI 0I SOTOPE	0	0		56. 00
57.00	05700 CT SCAN	0	0		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	0	0		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		٥		67. 00
68. 00	06800 SPEECH PATHOLOGY		0	l .	68. 00
		0			1
69. 00	06900 ELECTROCARDI OLOGY	0		l .	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l control of the cont	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	39		73. 00
73. 01	07302 OP PHARMACY	0	0		73. 01
74.00	07400 RENAL DIALYSIS	0	0		74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	0		90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0		90. 01
90. 02	09002 WOUND CARE CENTER	0	Ö	·	90. 02
90. 03	09003 PAIN CLINIC	0	0	l control of the cont	90. 03
90. 05	09005 OP PSYCH CLINIC	0	0		90. 05
91. 00	09100 EMERGENCY				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1		92.00
92.00		1 0	0	<u>'</u>	92.00
04.00	OTHER REIMBURSABLE COST CENTERS				- 04 00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	/	94. 00
95.00	09500 AMBULANCE SERVICES	0			95. 00
200.00	,	0	39	/	200. 00
201.00		0			201. 00
	Only Charges				
202.00	Net Charges (line 200 - line 201)	0	39		202. 00

Health Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		Inlie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	Provider C	CN: 15-0051	Period: From 01/01/2018 Fo 12/31/2018	Worksheet D Part I	pared:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 651, 479	0	3, 651, 479	9 48, 423	75. 41	30.00
31.00 INTENSIVE CARE UNIT	350, 872		350, 872	4, 035	86. 96	31.00
32. 00 CORONARY CARE UNIT	393, 022		393, 022	3, 424	114. 78	32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	217, 431		217, 43°	1 3, 748	58. 01	35. 00
41. 00 SUBPROVI DER - I RF	318, 168	0	318, 168	2, 834	112. 27	41.00
42. 00 SUBPROVI DER	0	0		0	0.00	42. 00
43. 00 NURSERY	106, 140		106, 140	3, 495	30. 37	43.00
200.00 Total (lines 30 through 199)	5, 037, 112		5, 037, 112	2 65, 959		200. 00
Cost Center Description	I npati ent	Inpatient				
· ·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				

		6. 00	7. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	375	28, 279	30	0. 00
31.00	INTENSIVE CARE UNIT	190	16, 522	3	1.00
32.00	CORONARY CARE UNIT	0	0	3:	2. 00
35.00	NEONATAL INTENSIVE CARE UNIT	10	580	3!	5. 00
41.00	SUBPROVI DER - I RF	13	1, 460	4	1.00
42.00	SUBPROVI DER	0	0	4:	2. 00
43.00	NURSERY	1, 641	49, 837	4:	3. 00
200.00	Total (lines 30 through 199)	2, 229	96, 678	200	0.00
		•		·	

	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/28/2019 12:	pared: 09 pm
		Ti tI	e XIX	Hospi tal	PPS	0 / p
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	T	T			-
50. 00 05000 OPERATI NG ROOM	1, 429, 068				8, 535	
50. 01 05001 CV SURGERY	0		0. 00000		0	
51. 00 05100 RECOVERY ROOM	175, 361				927	
52.00 05200 DELIVERY ROOM & LABOR ROOM	861, 744	39, 561, 676			13, 684	
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	546, 061	45, 108, 582	1		5, 067	
55. 00 05500 RADI OLOGY-THERAPEUTI C	569, 261	98, 962, 524			593	
56. 00 05600 RADI OI SOTOPE	0	_	0.00000		0	
57. 00 05700 CT SCAN	46, 869				396	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	52, 646			· ·	337	
59. 00 05900 CARDI AC CATHETERI ZATI ON	190, 313		1		342	
60. 00 06000 LABORATORY	562, 943	96, 552, 046			6, 278	
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	1
65. 00 06500 RESPI RATORY THERAPY	81, 727		1	· ·	3, 259	
66. 00 06600 PHYSI CAL THERAPY	362, 897				1, 875	
67. 00 06700 OCCUPATI ONAL THERAPY	0	_	0. 00000		0	
68. 00 06800 SPEECH PATHOLOGY	0	_	0. 00000		0	
69. 00 06900 ELECTROCARDI OLOGY	80, 712				726	
70. 00 07000 ELECTROENCEPHALOGRAPHY	117, 341	14, 217, 782			641	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	201, 797				1, 261	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	353, 394		1	· ·		
73.00 07300 DRUGS CHARGED TO PATIENTS	488, 577	176, 318, 541	1		6, 766	
73. 01 07302 OP PHARMACY	0	_	0.00000		0	
74. 00 07400 RENAL DI ALYSI S	35, 028				1, 862	
75. 00 07500 ASC (NON-DISTINCT PART)	0	_	0.0000		0	
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	_	0.00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	100, 188	3, 093, 904	0. 03238	2 10, 666	345	76. 97
OUTPATIENT SERVICE COST CENTERS	000 050	0.700.110	0.46007			
90. 00 09000 CLI NI C	280, 952		1		0	
90. 01 09001 OP ONCOLOGY INFUSION CENTER	142, 217		1	· ·	485	
90. 02 09002 WOUND CARE CENTER	121, 829				0	
90. 03 09003 PAIN CLINIC	74, 080		1		0	
90. 05 09005 OP PSYCH CLINIC	308, 732				69	
91. 00 09100 EMERGENCY	807, 888				4, 484	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	340, 391	30, 821, 567	0. 01104	4 82, 302	909	92.00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S			0.00000		0	94.00
95. 00 09500 AMBULANCE SERVICES		1	0.00000		0	95.00
200.00 Total (lines 50 through 199)	0 222 014	1 220 210 440		10, 207, 141	41 242	200. 00
200.00 Total (Tries 50 through 199)	0, 332, 016	1, 329, 319, 449	Ί	10, 207, 141	01, 243	₁ 200.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS	TS Provider C	CN: 15-0051 P	eri od:	Worksheet D	
			F	rom 01/01/2018	Part III	
			T	o 12/31/2018		pared:
					5/28/2019 12:	09 pm_
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0) 0	0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	0			0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	1	1	0	Ö	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			1	0	0	35. 00
	0	l ~	1	0	_	
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	0	0) 0	0	0	43. 00
200.00 Total (lines 30 through 199)	0	0	0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	, i		,	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	48, 423	0.00	375	30.00
31. 00 03100 I NTENSI VE CARE UNI T						1
32. 00 03200 CORONARY CARE UNIT			3, 424			ı
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			3, 748			ı
41. 00 04100 SUBPROVI DER - I RF	0	1	2, 834			
42. 00 04200 SUBPROVI DER	0	0	1	0.00		42. 00
43. 00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0	65, 959		2, 229	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31. 00 03100 NTENSI VE CARE UNI T	0	•				31. 00
32. 00 03200 CORONARY CARE UNIT		1				32.00
		1				
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
41. 00 04100 SUBPROVI DER - I RF	0	l .				41. 00
42. 00 04200 SUBPROVI DER	0					42. 00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Provider CCN: 15-0051 THROUGH COSTS

				0 12/31/2018	5/28/2019 12:	
		Ti tl	e XIX	Hospi tal	PPS	07 piii
Cost Center Description	Non Physician			Allied Health		
'	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	(0)	0	0	50. 00
50. 01 05001 CV SURGERY		0) (0	0	50. 01
51.00 05100 RECOVERY ROOM) c		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM				0	0	52.00
53. 00 05300 ANESTHESI OLOGY) c) (0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C) c) (0	0	55. 00
56. 00 05600 RADI 01 SOTOPE		0) (0	0	56. 00
57. 00 05700 CT SCAN) c) (0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)) c) (0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON) c) (0	0	59. 00
60. 00 06000 LABORATORY) c) (0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY) c) (0	0	64.00
65. 00 06500 RESPIRATORY THERAPY) c) (0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY) c) (0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY) c) (0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	() c) (0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY) C) (0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY) C) (0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS) C) (0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS) C) (0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS) C		0	474, 333	
73. 01 07302 OP PHARMACY) C		0	0	73. 01
74. 00 07400 RENAL DI ALYSI S) C		0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0		0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				0	0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON) <u> </u>) () 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLI NI C		C	1		0	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER				0	0	90. 01
90. 02 09002 WOUND CARE CENTER				0	0	90. 02
90. 03 09003 PAIN CLINIC				0	0	90. 03
90. 05 09005 OP PSYCH CLINIC				0	0	90.05
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)			,		0	91. 00 92. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REIMBURSABLE COST CENTERS		/)	U	92.00
94. 00 09400 HOME PROGRAM DIALYSIS) () 0	0	94.00
95. 00 09500 AMBULANCE SERVICES		ή	1	ا ا	U	95.00
200.00 Total (lines 50 through 199)				0	474, 333	
200.00 10tal (11103 00 till ough 177)	1	1	1	ή Θ	7,7,333	1200.00

 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

5/28/2019	
Title XIX Hospital PP	
Cost Center Description All Other Total Cost Total Total Charges Ratio of Co	st
Medical (sum of cols. Outpatient (from Wkst. C, to Charge	;
Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ c	ol.
4) cols. 2, 3, 8) 7)	
and 4)	
4.00 5.00 6.00 7.00 8.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0 0 201, 032, 079 0. 000	
50. 01 05001 CV SURGERY	
51. 00 05100 RECOVERY ROOM 0 0 31, 313, 685 0. 000	•
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 39, 561, 676 0. 000	
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 45, 108, 582 0. 000	
55. 00 05500 RADI OLOGY_THERAPEUTI C 0 0 98, 962, 524 0. 000	
56. 00 05600 RADI 0I SOTOPE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
57. 00 05700 CT SCAN 0 0 26, 814, 322 0. 000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 8, 859, 864 0.000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 63, 600, 103 0. 000	
60. 00 06000 LABORATORY 0 0 96, 552, 046 0. 000	•
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0. 000	00 64.00
65. 00 06500 RESPI RATORY THERAPY 0 0 14, 580, 246 0. 000	00 65.00
66. 00 06600 PHYSI CAL THERAPY 0 0 29, 294, 610 0. 000	00 66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0. 000	00 67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0. 000	00 68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 21, 867, 766 0. 000	00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 14, 217, 782 0. 000	00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 75,657,223 0.000	00 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 117, 439, 983 0.000	00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 474, 333 474, 333 176, 318, 541 0. 002	90 73.00
73.01 07302 OP PHARMACY O O O O O O O O	00 73. 01
74. 00 07400 RENAL DI ALYSIS 0 0 4, 654, 015 0.000	00 74.00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0	00 75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0	00 75. 01
76. 97 07697 CARDIAC REHABILITATION 0 0 3, 093, 904 0.000	00 76. 97
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 2, 799, 119 0. 000	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER 0 0 17, 518, 614 0. 000	90. 01
90. 02 09002 WOUND CARE CENTER 0 0 6, 333, 926 0. 000	90.02
90. 03 09003 PAIN CLINIC 0 0 0 2, 902, 592 0. 000	90.03
90. 05 09005 OP PSYCH CLINIC 0 0 2, 493, 323 0.000	90.05
91.00 09100 EMERGENCY 0 0 197,521,357 0.000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 30, 821, 567 0.000	92.00
OTHER REIMBURSABLE COST CENTERS	
94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0.000	94.00
95. 00 09500 AMBULANCE SERVI CES	95. 00
200.00 Total (lines 50 through 199) 0 474, 333 474, 333 1, 329, 319, 449	200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

					10 12/31/2010	5/28/2019 12:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	n Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	1, 200, 635		0	_	50. 00
50. 01	05001 CV SURGERY	0. 000000	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	165, 532		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	628, 243		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	418, 615		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	103, 121		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	226, 407		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	56, 781		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	114, 202		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 076, 775		0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	581, 454		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	151, 384		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	196, 589		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	77, 728		0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	472, 981		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	798, 153		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002690	2, 441, 677	6, 50	58 0	0	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0		0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 000000	247, 381		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	10, 666		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 000000	59, 684		0 0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0. 000000	0		0 0	0	90. 02
90. 03	09003 PAIN CLINIC	0. 000000	0		0	0	90. 03
90.05	09005 OP PSYCH CLINIC	0. 000000	555		0 0	0	90. 05
91.00	09100 EMERGENCY	0. 000000	1, 096, 276		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	82, 302		0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		10, 207, 141	6, 5	68 0	0	200. 00

		U HEALTH BLOOMI	NGTON HOSPITAL			u of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od:	Worksheet D	
			Component		From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/28/2019 12:	pared: 09 pm
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	'	Related Cost	(from Wkst. C,	to Charges	Program	column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	·				
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 429, 068	201, 032, 079	0.00710	9 0	0	50. 00
50. 01	05001 CV SURGERY	0	0	0.00000	0	0	50. 01
51.00	05100 RECOVERY ROOM	175, 361	31, 313, 685	0.00560	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	861, 744	39, 561, 676	0. 02178	2 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	546, 061	45, 108, 582	0. 01210	5 3, 459	42	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	569, 261	98, 962, 524	0.00575	2 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	1	0.00000		0	56.00
57.00	05700 CT SCAN	46, 869	26, 814, 322	0.00174		0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	52, 646		0. 00594	2 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	190, 313	63, 600, 103	0. 00299	2 0	0	59.00
60.00	06000 LABORATORY	562, 943				14	60.00
64.00	06400 I NTRAVENOUS THERAPY	0		0. 00000		0	64.00
65. 00	06500 RESPIRATORY THERAPY	81, 727	14, 580, 246	•		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	362, 897		•		329	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0.00000		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	80, 712	21, 867, 766			0	69. 00
70. 00		117, 341	1 ' '			0	70.00
71. 00		201, 797				1	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	353, 394				0	72. 00
73. 00		488, 577		0. 00277		22	73. 00
73. 01	07302 OP PHARMACY	0		0.00000			73. 01
74. 00		35, 028	4, 654, 015			0	74. 00
75. 00		0		0.00000		0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1	0. 00000		0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	100, 188				0	1
70. 77	OUTPATIENT SERVICE COST CENTERS	100, 100	0,070,701	0.00200	2		70.77
90. 00		280, 952	2, 799, 119	0. 10037	2 0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	142, 217			-	0	90. 01
90. 02		121, 829				0	90. 02
90. 03		74, 080	1 ' '			0	90. 03
90. 05	09005 OP PSYCH CLINIC	308, 732			-1	0	90.05
91. 00		807, 888		0. 00409		0	91.00
92. 00		007,000		0.00000		0	1
,2.00	OTHER REIMBURSABLE COST CENTERS		00,021,007	3.00000	<u> </u>	0	1 /2.00
94, 00	09400 HOME PROGRAM DI ALYSIS	0	0	0.00000	0 0	0	94. 00

7, 991, 625 1, 329, 319, 449

0

40, 895

0 94.00 95.00 408 200.00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT . THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 12:09 pm

						5/28/2019 12:	09 pm
			Ti tl	e XIX	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Non Physician	Nursing School	Nursing School		Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0	0	50.00
50. 01	05001 CV SURGERY	0	ol c) (0	0	50. 01
51.00	05100 RECOVERY ROOM	0	ol c) (0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	ol c	ol c	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0			0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					i o	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C					ň	55.00
56. 00	05600 RADI OI SOTOPE					ň	56.00
57. 00	05700 CT SCAN					0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)					0	58.00
						0	
59.00	05900 CARDI AC CATHETERI ZATI ON					0	59.00
60.00	06000 LABORATORY					0	60.00
64. 00	06400 NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0) C		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0) C		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0) C)	0	0	67. 00
	06800 SPEECH PATHOLOGY	0) C) (0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0) C) (0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0) C) (0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0) C) (0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0) C) (0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (0	474, 333	73. 00
73. 01	07302 OP PHARMACY	0	C		0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	ol c) (0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	ol c) (0	0	75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		ol c	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0		ol c	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	_					
90.00	09000 CLI NI C	0) () (0	0	90.00
	09001 OP ONCOLOGY INFUSION CENTER	0			0	o o	90. 01
	09002 WOUND CARE CENTER					i o	90. 02
	09003 PAIN CLINIC					ň	90. 03
	09005 OP PSYCH CLINIC					0	90.05
	09100 EMERGENCY					0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1		0	92.00
92.00			<u>'</u>		<i>)</i>	U	92.00
04.00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS) .) (0	04.00
94. 00		0	1	ή	0	0	,
	09500 AMBULANCE SERVICES			,	,	474 000	95. 00
200.00	Total (lines 50 through 199)	0) C) (0	474, 333	J200. 00

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS	VICE OTHER PASS			Period: From 01/01/2018 To 12/31/2018		pared:
		Titl	e XIX	Subprovi der - I RF	PPS	57 p
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	4. 00	5. 00	and 4) 6,00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	6.00	
50. 00 05000 OPERATING ROOM	0	0		0 201, 032, 079	0.000000	50.00
50. 01 05001 CV SURGERY	0	0		0 201, 002, 077	0.000000	50. 01
51. 00 05100 RECOVERY ROOM	0	0		0 31, 313, 685		51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 39, 561, 676	l .	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 45, 108, 582	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 98, 962, 524	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		o	0. 000000	56.00
57. 00 05700 CT SCAN	0	0		0 26, 814, 322	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 8, 859, 864	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 63, 600, 103	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 96, 552, 046	0.000000	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 14, 580, 246	l .	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 29, 294, 610	0.000000	66.00

	<u> </u>	U HEALTH BLOOMING	_			eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	Provi der C		Peri od: From 01/01/2018	Worksheet D Part IV	
THROUG	in COSTS		Component		To 12/31/2018		pared: 09 pm
			Ti tI	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0. 000000	0		0	1	
50. 01	05001 CV SURGERY	0. 000000	0	l .	0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	0	1	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0)	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 459	1	0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0)	0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0)	0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0)	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	1	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	2, 413		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0)	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	0)	0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	26, 562		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0)	0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	,	0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	,	0 0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	474	l .	0 0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	,	0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0.002690	7, 987	2	1 0	0	1
73. 01	07302 OP PHARMACY	0. 000000	. 0		0	0	73. 01
74. 00	07400 RENAL DIALYSIS	0. 000000	0	,	0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	1	0 0	0	1
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	_	1
70.77	OUTPATIENT SERVICE COST CENTERS	0.00000		1	<u> </u>		1
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 000000	0	1	o o	_	1
90. 02	09002 WOUND CARE CENTER	0. 000000	0	1	o o	1	1
90. 03	09003 PAIN CLINIC	0. 000000	0	1	0 0	1	
90. 05	09005 OP PSYCH CLINIC	0. 000000	0		0 0	1	1
91. 00	09100 EMERGENCY	0. 000000	0	l .	0 0	1	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	1	0 0	0	1
,2.00	OTHER RELABILE COST CENTERS	0.000000	0	1	<u> </u>		1 /2.00

0.000000

40, 895

0 94.00 95.00 0 200.00

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09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	IU HEALTH BLOOMINGTO	ON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prep 5/28/2019 12:0	
		Title XVIII	Hospi tal	PPS	
Cost Contan Decemintion		,			

Cost Center Description 1.00 PART 1 - ALL PROVIDER COMPONENTS NAME BY LANGE BY LOWER COMPONENTS NAME BY LOWER COMPONEN			Ti +Lo VVIII	Hospi tal	5/28/2019 12: PPS	09 pm
NACT 1 - ALL PROVIDER COMPONENTS 1.00		Cost Center Description	Title XVIII	Hospi tal	PPS	
IMPAILENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 48,433 2.00 100 Inpatient days (including private room days, axcluding swing-bed day nemborn days) 3.00 2.00 10patient days (including private room days, axcluding swing-bed and nemborn days) 3.00					1. 00	
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				1, 236. 64	38. 00
		, , ,	-			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 22,581,046 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	Tiotal Program general inpatient routine service cost (line 39	+ IINE 40)	l	22, 581, 046	41.00

		IU HEALTH BLOOMIN		N. 15 0054		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2018	Worksheet D-1	
					Го 12/31/2018	Date/Time Prep 5/28/2019 12:0	pared: 09 pm
	Cost Center Description	Total	Ti tl e Total		Hospi tal	PPS	
	cost center bescription	Total Inpatient Cost		Average Per Diem (col. 1 -	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4. 00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00		5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units					0 (0) 501	
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 028, 626 5, 426, 928	4, 035 3, 424	1, 741. 9 ⁻ 1, 584. 9 ⁻		3, 694, 591 2, 672, 259	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT	0, 120, 720	0, 121	1,001.7	1,000	2,072,207	45. 00
46.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	4 249 204	2 740	1 140 1	4 0		46.00
47.00	Cost Center Description	4, 348, 204	3, 748	1, 160. 14	+ 0	U	47. 00
10.00						1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			15)		32, 181, 106 61, 129, 002	1
17.00	PASS THROUGH COST ADJUSTMENTS	• • • • • • • • • • • • • • • • • • • •				01, 127, 002	17.00
50. 00	Pass through costs applicable to Program in	patient routine s	services (from	Wkst. D, sum	of Parts I and	1, 754, 948	50. 00
51. 00	Pass through costs applicable to Program in	patient ancillary	y services (fro	om Wkst. D, su	um of Parts II	1, 103, 265	51.00
F0 00	and IV)		,			0.050.040	F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated non-phys	sician anesthe	etist and	2, 858, 213 58, 270, 789	1
	medical education costs (line 49 minus line					,,	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	ting cost and tax	rgot amount (Li	no E4 minus I	ino E2)	0	
58. 00	Bonus payment (see instructions)	ting cost and tai	rget amount (11	THE SO IIII HUS I	THE 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	endi ng 1996, up	dated and cor	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. upo	dated by the ma	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	es 55, 59 or 60 e	enter the Lesse	er of 50% of t		0	ı
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x 6	60), or 1% of	the target		
	Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instrud	ctions)			0	63. 00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decembe	or 21 of the co	et roporting	norial (Soc	o	65. 00
03.00	instructions)(title XVIII only)			. 0			05.00
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line 6	64 plus line 65	5)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 of	the cost rep	porting period	o	67. 00
40.00	(line 12 x line 19)	no ocata often De		he east mana	ating popied		40.00
68.00	Title V or XIX swing-bed NF inpatient routile (line 13 x line 20)	ne costs arter be	ecember 31 01 t	.ne cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci						70.00
71. 00	Adjusted general inpatient routine service	cost per diem (li		, ,			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 x lir	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine ser			10 00)			74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from Wo	orksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		rovi der records	5)			78. 00 79. 00
80.00	Total Program routine service costs for com	parison to the co			us line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation ()				81. 00 82. 00
	Reasonable inpatient routine service costs						83. 00
83. 00	15	nstructions)					84. 00
83. 00 84. 00	Program inpatient ancillary services (see in		20)				
83. 00 84. 00 85. 00	Utilization review - physician compensation Total Program inpatient operating costs (su	(see instruction					85. 00 86. 00
83. 00 84. 00 85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sw PART IV - COMPUTATION OF OBSERVATION BED PAS	(see instruction m of lines 83 thm SS THROUGH COST					86. 00
83. 00 84. 00 85. 00	Utilization review - physician compensation Total Program inpatient operating costs (su	(see instruction m of lines 83 thm SS THROUGH COST s)	rough 85)			4, 514 1, 236. 64	86. 00 87. 00

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/28/2019 12:	pared: 09 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	3, 651, 479	59, 881, 625	0. 06097	5, 582, 193	340, 391	90. 00
91.00 Nursing School cost	0	59, 881, 625	0.00000	5, 582, 193	0	91.00
92.00 Allied health cost	0	59, 881, 625	0.00000	5, 582, 193	0	92. 00
93.00 All other Medical Education	0	59, 881, 625	0.00000	5, 582, 193	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2018	Worksheet D-1	
	Component CCN: 15-T051	To 12/31/2018	Date/Time Prepared: 5/28/2019 12:09 pm	
	Title XVIII	Subprovi der -	PPS	

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 834	1. 00
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day			2, 834	2.00
3. 00	do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 834	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber s	in or the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 21	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	arter becember 31	of the cost	O	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 850	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (i neludi na privato re	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		ioiii days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frictualing private	(100 days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye		, I	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excidding swing-bed d	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	- through December 21 of	: 4b4	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
17.00	reporting period	s through becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		2, 539, 110	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the cost reporting	noried (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	perrou (Trile 6	U	23. 00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	ported (line 9	0	25. 00
25.00	x line 20)	or the cost reporting	perrou (Trile 8	O	25.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		2, 539, 110	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	Line 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	F ITHE 28)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•	1	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	2, 539, 110	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			895. 95	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 657, 508	
40.00	Medically necessary private room cost applicable to the Program	,		1 457 509	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	I	1, 657, 508	41.00

	Financial Systems IL	J HEALTH BLOOMIN				eu of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C Component	CCN: 15-0051	Period: From 01/01/2018 To 12/31/2018		
			Title	xVIII	Subprovi der -	5/28/2019 12: PPS	09 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col . 3 x col . 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	O O		0.	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	C	•			1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	С	0.	00 0	0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	C	0.	00 0	0	47. 00
	·					1.00	
48. 00	Program inpatient ancillary service cost (Wks			>		1, 917, 837	•
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	see instructio	ins)		3, 575, 345	49.00
50.00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, su	m of Parts I and	207, 700	50.00
51. 00	<pre> </pre>	atient ancillary	/ services (fr	om Wkst D	sum of Parts II	58 500	51.00
	and IV)	-	, 50, 7,003 (11	om mot. D _i	Jam Or Furts II		
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		atod non ni-	rei ei en ense±	notist and	266, 200 3, 309, 145	
53.00	medical education costs (line 49 minus line !		ateu, non-pny	SICIAN ANESTI	netrst, and	3, 309, 145	53.00
E 4 . 0.0	TARGET AMOUNT AND LIMIT COMPUTATION						F 4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	endi ng 1996, ເ	pdated and c	ompounded by the		59.00
	market basket					0.00	,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than	n expected costs					
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doson	phor 21 of the	cost report	ing pariod (Sac	1 0	64. 00
04.00	instructions) (title XVIII only)	ts through becen	iber 31 of the	cost report	riig perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the d	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 6	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	o costs through	Docombor 21 o	of the cost r	operting period	0	67. 00
67.00	(line 12 x line 19)	e costs through	becember 31 c	i the cost in	eporting period		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (I	ine 67 + line	68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU				<u> </u>		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co				,		70.00
72.00	Program routine service cost (line 9 x line	71)					72.00
73. 00 74. 00	Medically necessary private room cost application and the service of the service						73.00
75. 00	Capital-related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	· · · · · · · · · · · · · · · · · · ·						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	.*	ovider record	(s)			78. 00 79. 00
80.00	Total Program routine service costs for compa				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 00)			l	30.00
87. 00 88. 00	Total observation bed days (see instructions)		Line 2)			0 00	87. 00 88. 00
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	11110 2)				89.00
		ŕ				•	•

Health Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL		In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 12:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	OST					
90.00 Capital -related cost	318, 168	2, 539, 110	0. 12530	7 0	0	90. 00
91.00 Nursing School cost	0	2, 539, 110	0.00000	0	0	91. 00
92.00 Allied health cost	0	2, 539, 110	0.00000	0	0	92.00
93.00 All other Medical Education	0	2, 539, 110	0. 00000	0	0	93. 00
93.00 All other Medical Education	0	2, 539, 110	0. 00000	0	0	93. 00

	LILLUEALTH BLOOMINGTON HOODITAL		C.E. OHO	2550 40
Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2018	Worksheet D-1	
		To 12/31/2018	Date/Time Pre 5/28/2019 12:	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

Description Description D			Title XIX	Hospi tal	5/28/2019 12: PPS	09 pm
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description		·	1 00	
Impatient days (Including private room days and seing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days)	4 00				40, 400	4 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do 3 on 5 o						
5.00 Semi-private room days (excluding swing-bed and observation bed days) 4.0, one of the cost reporting period of swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of feat enders were, enter 0 on this it ine) 1.7, one of the cost reporting period of the cost period of the cost reporting period of the cos		Private room days (excluding swing-bed and observation bed day		vate room days,		
5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal Institute private room days) after December 31 of the cost of Potal Institute Program (and Ins	4. 00	·	ed days)		43, 909	4. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost ropering period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0 on this line) Representation of the cost reporting period (if calendar year, enter 0		Total swing-bed SNF type inpatient days (including private roo		31 of the cost		
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost proporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) 7.00 Incl Inpatient days including private room days applicable to the Program (excluding swing-bed and private room days) and through December 31 of the cost reporting period (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to the tile XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 7.00 Swing-bed NF type inpatient days applicable to the tile XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost opporting period (including private room days) 8.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost opporting period (including private room days) 8.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost opporting period (including private room days) 8.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 8.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the co	6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
10.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 7.00	7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
Total Inpatient days Including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00	8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	l of the cost	0	8. 00
10.00 Swing-bed SWF type Inpatient days applicable to title XVIII only (Including private room days) 10.00	9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	375	9. 00
11.00 Swing-bed SNF type Inpatient days applicable to fittle XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Mursery days (title V or XIX only) 17.00 Mursery days (title V or XIX only) 18.00 Mursery days (title V or XIX only) 18.00 Mursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x x line 17) 20.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x x line 17) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x x lin	10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{V} \) or XIX only (including private room days) 0 12.00	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including privater room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line) 14.00	12. 00	Swing-bed NF type inpatient days applicable to titles V or XI>		e room days)	0	12. 00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 Nursery days (title V or XIX only) 1,641 16.00 Nursery days (title V or XIX only) 1,641 17.00 Nursery days (title V or XIX only) 1,641 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period or swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Teporting period 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	13. 00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13. 00
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19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (30.00 Total general inpatient routine service cost (see instructions) (20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (1 ine 5 x line 17) (20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (1 ine 6 x 1 line 18) (20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1 ine 6 x 1 line 18) (20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1 ine 6 x 1 line 18) (20.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1 ine 8 x 1 line 20) (20.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (1 ine 8 x 1 line 20) (20.00 Total swing-bed cost (see instructions) (20.00 Seneral inpatient routine service cost net of swing-bed and observation bed charges) (20.00 Private room charges (excluding swing-bed charges) (20.00 Seneral inpatient routine service cost/charge ratio (line 27 + line 28) (20.00 Seneral inpatient routine service cost/charge ratio (line 27 + line 28) (20.00 Seneral inpatient routine service cost fefferential (line 32 minus line 33) (see instructions) (20.00 Seneral inpatient routine service cost of ifferential (line 32 minus line 33) (see instructions) (20.00 Seneral inpatient routine service cost period see instructions) (20.00 Seneral inpatient routine service cost period see instructions) (20.00 Seneral inpatient routine service cost period see instructions) (20.00 Seneral inpatient routine service cost period see instructions) (20.00 S	18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
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	Financial Systems I ATION OF INPATIENT OPERATING COST	U HEALTH BLOOMIN	NGTON HOSPITAL Provider CO	N: 15_0051	In Lie	worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider Co		From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared: 09 pm_
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1. 00 1, 580, 576	2. 00 3, 495	3. 00 452. 2	4. 00 4 1, 641	5. 00 742, 126	42.00
	Intensive Care Type Inpatient Hospital Units		·				
43.00	INTENSIVE CARE UNIT	7, 028, 626	4, 035	-			
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	5, 426, 928	3, 424	1, 584. 9	0	0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	4, 348, 204	3, 748	1, 160. 1	4 10	11, 601	47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 722, 673	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		3, 271, 103	49. 00
50. 00	Pass through costs applicable to Program inc	atient routine s	services (from	Wkst. D, sum	of Parts I and	95, 218	50.00
F1 00	III)			WI+ D -	£ Dt- 11	/7.011	F1 00
51. 00	Pass through costs applicable to Program inpand IV)	atient anciliary	y services (Tr	OM WKST. D, S	um or Parts II	67, 811	51.00
52. 00	Total Program excludable cost (sum of lines					163, 029	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesth	etist, and	3, 108, 074	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					l e	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and tai	rget amount (I	ine 56 minus	line 53)	ő	
58. 00	Bonus payment (see instructions)		" 4007			0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period (ending 1996, u	paatea ana co	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					l e	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		s (TITIES 54 X	60), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Necembe	ar 31 of the c	ost reporting	nariad (Saa	0	65. 00
	instructions)(title XVIII only)					Ĭ	05.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	porting period	0	67. 00
	(line 12 x line 19)		. 01 6				
68. 00	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	ie costs arter De	ecember 31 or	tne cost repo	rting perioa	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	•				0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service of						71.00
72. 00	Program routine service cost (line 9 x line			05)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73.00
75. 00	Capital -related cost allocated to inpatient	•		orksheet B, P	art II, column		75. 00
74 00	26, line 45)	no 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	,		_			78. 00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*	us line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		55t Tim tati OII	(1116 70 11111	us 11110 /7)		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					4, 514	87. 00
88. 00	Adjusted general inpatient routine cost per	•	line 2)			1, 236. 64	
	Observation bed cost (line 87 x line 88) (se					5, 582, 193	

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2018	Worksheet D-1	
				Γο 12/31/2018	Date/Time Prep 5/28/2019 12:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (OST					
90.00 Capital -related cost	3, 651, 479	59, 881, 625	0. 060978	5, 582, 193	340, 391	90.00
91.00 Nursing School cost	0	59, 881, 625	0.00000	5, 582, 193	0	91.00
92.00 Allied health cost	0	59, 881, 625	0.00000	5, 582, 193	0	92.00
93.00 All other Medical Education	0	59, 881, 625	0.000000	5, 582, 193	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T051		
	Title XIX	Subprovi der -	PPS
		LDE	

		II tie xix	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 834	1.00
2.00	Inpatient days (including private room days, excluding swing-b			2, 834	
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		2, 834	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period			_	
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	11 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n davs) through December	31 of the cost	0	7. 00
	reporting period	, .,		-	
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing_hed and	13	9. 00
7. 00	newborn days)	the frogram (exerualing	Swifing bed and	13	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct		om dovo) often		11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ve			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(gg	,	3, 495	15. 00
16. 00	Nursery days (title V or XIX only)			1, 641	16. 00
17 00	SWING BED ADJUSTMENT	as through Dagambar 21 of	the east	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions		ng poriod (line	2, 539, 110	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ig period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(1: 21 -: 1: 2/)		0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		2, 539, 110	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3)	Fline 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	i ons)	0. 00	
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	ferential (line	2, 539, 110	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			895. 95	
39. 00	Program general inpatient routine service cost (line 9 x line			11, 647	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 11, 647	
11.00	1. star sgram general impatriont routine service cost (Time 37		1	11,047	

	Financial Systems IL	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-0051 CCN: 15-T051	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			Titl	e XIX	Subprovi der -	5/28/2019 12: PPS	09 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	·	Inpatient Cost	Inpatient Days			(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	-					
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	•		0	1
45. 00	BURN INTENSIVE CARE UNIT		O	0.	0		45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0.	00	0	46. 00 47. 00
47.00	Cost Center Description	<u> </u>		0.	001 0		47.00
48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	. line 200)			1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS			ns)			49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, su	n of Parts I and	1, 460	50. 00
51. 00	<pre>Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	429	51.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				1, 889	52. 00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		lated, non-phy	sician anest	netist, and	23, 153	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0 0	
58.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period	enaing 1996, t	ipdated and c	ompounded by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	
01.00	which operating costs (line 53) are less than	n expected cost					01.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing		•		•	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	_				0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient :	routine costs (line 67 + line	. 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			1
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co				,		70.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(lino 14 v li	no 25)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)		costs (from W	orksheet B, I	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)	roul don mass	le)			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on			•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see insultilization row) when the program is a component of the program in the program i		ne)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	THROUGH COST				0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	In Lieu of Form CMS-2		
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1		
		Component (From 01/01/2018 To 12/31/2018		pared: 09 pm	
		Ti tl	e XIX	Subprovi der – I RF	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost	1	
				line 89)	(col. 3 x col.		
					4) (see	1	
					instructions)		
	1.00	2. 00	3.00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	318, 168	2, 539, 110	0. 12530	7 0	0	90.00	
91.00 Nursing School cost	0	2, 539, 110	0. 00000	0	0	91.00	
92.00 Allied health cost	0	2, 539, 110	0. 00000	0 0	0	92.00	
93.00 All other Medical Education	0	2, 539, 110	0. 00000	0 0	0	93. 00	

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Lieu of Form CMS-2552-10
INDATIONS ANGLE ADVICEDURGE COCT ADDODELONMENT		D: -I CON 15 0051	D!I	WI+ D 2

Heal th Finar	ncial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Li€	eu of Form CMS-:	2552-10
	NCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 15-0051	Peri od:	Worksheet D-3	
					From 01/01/2018		
					To 12/31/2018		
			T: +1 o	VVIII	Hooni tol	5/28/2019 12:	09 pm
	Coot Conton Decemention		IIIIe	Ratio of Cos	Hospi tal	PPS	
	Cost Center Description				•	Inpatient	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
				1.00	2.00	2) 3. 00	
LNDAT	TIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3.00	
	ADULTS & PEDIATRICS				51, 498, 888		30.00
	INTENSIVE CARE UNIT				11, 659, 322		31.00
	CORONARY CARE UNIT				8, 613, 486		32.00
1	NEONATAL INTENSIVE CARE UNIT				0,013,400		35.00
	SUBPROVIDER - IRF						41.00
	SUBPROVI DER						42.00
•	NURSERY						43. 00
	LLARY SERVICE COST CENTERS						73.00
	OPERATING ROOM			0. 0950	98 36, 564, 585	3, 477, 219	50.00
	CV SURGERY			0.0000		0, 1,7, 217	1
	RECOVERY ROOM			0. 1904			1
	D DELIVERY ROOM & LABOR ROOM			0. 2000			1
	ANESTHESI OLOGY			0.0000			1
	RADI OLOGY-DI AGNOSTI C			0. 1525			
	RADI OLOGY-THERAPEUTI C			0. 0652			1
	RADI OI SOTOPE			0.0000		0	56.00
	CT SCAN			0. 0504			1
	MAGNETIC RESONANCE IMAGING (MRI)			0. 0869			
	CARDI AC CATHETERI ZATI ON			0. 0458			
	LABORATORY			0. 1563			60.00
	INTRAVENOUS THERAPY			0.0000		0	1
	RESPI RATORY THERAPY			0. 2797		1, 639, 097	1
	PHYSI CAL THERAPY			0. 4084			1
	OCCUPATIONAL THERAPY			0.0000			1
68. 00 06800	SPEECH PATHOLOGY			0.0000	00	0	68. 00
69. 00 06900	ELECTROCARDI OLOGY			0. 0787	03 6, 089, 066	479, 228	69. 00
70.00 07000	ELECTROENCEPHALOGRAPHY			0. 1302	15 1, 356, 877	176, 686	70. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6		0. 1990	17 11, 912, 223		
	IMPL. DEV. CHARGED TO PATIENTS			0. 2268			
	DRUGS CHARGED TO PATIENTS			0. 1938			1
1	OP PHARMACY			0.0000		0	
	RENAL DIALYSIS			0. 3369			1
	ASC (NON-DISTINCT PART)			0.0000		0	75. 00
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			0.0000		0	75. 01
	7 CARDI AC REHABI LI TATI ON			0. 4163	45 199, 900	83, 227	76. 97
	ATIENT SERVICE COST CENTERS CLINIC			0.04/0	2/ 10 270	0.010	00.00
	OP ONCOLOGY INFUSION CENTER			0. 9468			1
	WOUND CARE CENTER			0. 2677 0. 1936			90. 01 90. 02
	PAIN CLINIC			0. 1936.			1
	OP PSYCH CLINIC			1. 3375			90.05
	EMERGENCY			0. 0663			
	OBSERVATION BEDS (NON-DISTINCT PART))		0. 1811		269, 351	92.00
	R REIMBURSABLE COST CENTERS	<u>, </u>		0. 1011	1, 407, 201	207, 331	72.00
	HOME PROGRAM DIALYSIS			0.0000	00	0	94. 00
	AMBULANCE SERVICES			0.0000			95. 00
200. 00	Total (sum of lines 50 through 94 ar	nd 96 through 98)			204, 619, 539	32, 181, 106	
201.00	Less PBP Clinic Laboratory Services-		(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201		/		204, 619, 539		202. 00
,						•	•

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITA			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0051	Peri od:	Worksheet D-3	}
	Component	CCN: 15-T051	From 01/01/2018 To 12/31/2018		pared: 09 pm
	Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		_		1	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT					32.00
41. 00 04100 SUBPROVI DER - RF			3, 923, 039		35. 00 41. 00
42. 00 04200 SUBPROVI DER			3, 723, 037		42.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					10.00
50. 00 05000 OPERATING ROOM		0. 0950	98 23, 180	2, 204	50.00
50. 01 05001 CV SURGERY		0.0000	· ·		1
51. 00 05100 RECOVERY ROOM		0. 1904:		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 20008	30 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1525	53 39, 328	6, 000	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0652		614	
56. 00 05600 RADI 0I SOTOPE		0. 00000		0	
57. 00 05700 CT SCAN		0. 0504		l .	1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 08698	1	1, 121	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0. 04589		0 57 404	
64. 00 06400 I NTRAVENOUS THERAPY		0. 1563 0. 0000		57, 486 0	
65. 00 06500 RESPI RATORY THERAPY		0. 27978			
66. 00 06600 PHYSI CAL THERAPY		0. 4084			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 00000	1 1	0	1
68. 00 06800 SPEECH PATHOLOGY		0. 00000		Ō	
69. 00 06900 ELECTROCARDI OLOGY		0. 07870		1, 484	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1302	15 6, 145	800	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	S	0. 1990 ⁻	17 61, 520	12, 244	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 22680	9, 300	2, 109	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1938			
73. 01 07302 OP PHARMACY		0.0000		0	
74. 00 07400 RENAL DI ALYSI S		0. 3369			1
75. 00 07500 ASC (NON-DISTINCT PART)		0. 00000		0	
75. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CE		0.00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 4163	45 29, 127	12, 127	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC		0.0440	36 0	0	90.00
90. 00 09000 CETNIC 90. 01 09001 OP ONCOLOGY INFUSION CENTER		0. 94683 0. 26779			
90. 02 09002 WOUND CARE CENTER		0. 28773			
90. 03 09002 WOUND CARE CENTER		0. 1930.			

0.199546

1. 337545

0.066320

0. 181113

0.000000

0

37, 771

21, 575

5, 580, 910

5, 580, 910

90. 05

91.00

92.00

94.00

95.00

200. 00

201.00

202. 00

0 90.03

0

2, 505

3, 908

1, 917, 837

90.03

90.05

91.00

92.00

200.00

201.00

202.00

09003 PAIN CLINIC

09100 EMERGENCY

09005 OP PSYCH CLINIC

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OTHER REIMBURSABLE COST CENTERS

H	Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In	Lieu of Form CMS-2552-10
	INDATIENT ANGLE ADV CEDULOE COCT ADDODTI CHMENT		D ' I OON 45 0054	D!!	W I I I D O

Health Financial Systems TO HEALTH BLOOMINGTO	IN HUSPITAL		In Lie	u or Form CMS	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 01/01/2018		
			To 12/31/2018		pared:
				5/28/2019 12:	09 pm_
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			orial ges	2)	
		1.00	2.00	3. 00	
LADATI ENT. DOUTLAGE CEDALOE COCT. CENTEDO		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			3, 413, 125		30. 00
31.00 03100 INTENSIVE CARE UNIT			1, 227, 696		31. 00
32. 00 03200 CORONARY CARE UNI T			133, 447		32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			442, 937		35. 00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			o o		42. 00
			170 024		43.00
			170, 824		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 09509		114, 178	50.00
50. 01 05001 CV SURGERY		0.00000		0	50. 01
51. 00 05100 RECOVERY ROOM		0. 19042	9 165, 532	31, 522	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 20008	628, 243	125, 699	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15255		63, 861	
55. 00 O5500 RADI OLOGY-THERAPEUTI C		0. 06527		6, 732	
56. 00 05600 RADI 0I SOTOPE		0.00000		0, 732	56.00
					1
57. 00 05700 CT SCAN		0. 05044		11, 421	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 08698		4, 939	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 04589		5, 241	
60. 00 06000 LABORATORY		0. 15636	0 1, 076, 775	168, 365	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 27978	9 581, 454	162, 684	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 40841		61, 828	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 00000		01,020	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 07870		15, 472	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 13021		10, 121	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19901		94, 131	
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS		0. 22680	798, 153	181, 026	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 19385	5 2, 441, 677	473, 331	73.00
73. 01 07302 OP PHARMACY		0.00000	0	0	73. 01
74. 00 07400 RENAL DI ALYSI S		0. 33691		83, 347	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000		0	75. 00
				-	
		0. 41634	5 10, 666	4, 441	76. 97
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLI NI C		0. 94683		0	90. 00
90. 01 09001 0P ONCOLOGY INFUSION CENTER		0. 26775	8 59, 684	15, 981	90. 01
90. 02 09002 WOUND CARE CENTER		0. 19362	0.	0	90. 02
90. 03 09003 PAIN CLINIC		0. 19954	.6	0	90. 03
90. 05 09005 OP PSYCH CLINIC		1. 33754		742	
91. 00 09100 EMERGENCY		0. 06632		72, 705	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				14, 906	92.00
		0. 18111	3 02, 302	14, 900	92.00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DIALYSIS		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			10, 207, 141	1, 722, 673	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			10, 207, 141		202. 00
, , , , , , , , , , , , , , , , , , , ,		•		•	

lealth Financial Systems	IU HEALTH BLOOMI				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONM	ENT	Provi der Co	CN: 15-0051	Peri od: From 01/01/2018	Worksheet D-3	
		Component	CCN: 15-T051	To 12/31/2018	Date/Time Pre 5/28/2019 12:	pared:
		Ti tl	e XIX	Subprovi der - I RF	PPS	<u>0 7 p.ii.</u>
Cost Center Description			Ratio of Cos		Inpati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTER	RS		T			
0. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
1. 00 03100 I NTENSI VE CARE UNI T				0		31.00
2. 00 03200 CORONARY CARE UNIT				0		32.00
5. 00 02060 NEONATAL INTENSIVE CARE UNIT				0 000		35.00
1. 00 04100 SUBPROVI DER - RF				26, 000		41.00
2. 00 04200 SUBPROVI DER				0		42.00
3. 00 04300 NURSERY				0		43.00
ANCI LLARY SERVI CE COST CENTERS 0.00 OF OPERATING ROOM			0. 0950	98 0	0	E0 00
D. 00 05000 OPERATING ROOM D. 01 05001 CV SURGERY			0.0950			50. 00 50. 01
1. 00 05100 RECOVERY ROOM			0. 1904			51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM			0. 20008			52.00
3. 00 05300 ANESTHESI OLOGY			0. 00000		0	53.00
I. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1525!			54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C			0. 0652		0	55.00
6. 00 05600 RADI 0I SOTOPE			0. 00000		ĺ	56.00
7. 00 05700 CT SCAN			0. 0504		0	57.00
B. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 08698		Ö	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	,		0. 04589		Ö	59.00
D. 00 06000 LABORATORY			0. 1563		377	60.00
1. 00 06400 INTRAVENOUS THERAPY			0. 00000		0	64.00
5. 00 06500 RESPIRATORY THERAPY			0. 27978		0	65.00
6. 00 06600 PHYSI CAL THERAPY			0. 4084 ⁻	17 26, 562	10, 848	66.00
7. 00 06700 OCCUPATIONAL THERAPY			0. 00000	00	0	67.00
8.00 06800 SPEECH PATHOLOGY			0. 00000	00	0	68.00
9. 00 06900 ELECTROCARDI OLOGY			0. 07870	0	0	69.00
0.00 07000 ELECTROENCEPHALOGRAPHY			0. 1302	15 0	0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENTS		0. 1990 ⁻	17 474	94	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 22680	06 0	0	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS			0. 1938!	7, 987	1, 548	73.00
3. 01 07302 OP PHARMACY			0. 00000		0	73. 01
4.00 07400 RENAL DIALYSIS			0. 3369 ⁻		0	74.00
5. 00 07500 ASC (NON-DISTINCT PART)			0. 00000			75. 00
5. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI	CES		0. 00000			75. 01
6. 97 O7697 CARDI AC REHABI LI TATI ON			0. 4163	45 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			0.0448	24		00.00
0. 00 09000 CLI NI C			0. 9468			90.00

0. 267758 0.193620

0.199546

1. 337545

0.066320

0. 181113

0.000000

40, 895

40, 895

90. 01

90.02

90.05

91.00

94.00

95.00

201.00

202. 00

0

0 90.03

0

0

0 92.00

13, 395 200. 00

09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

09003 PAIN CLINIC

09100 EMERGENCY

09005 OP PSYCH CLINIC

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

90. 01

90.02

90.03

90.05

91.00

92.00

200.00

201.00

202.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 12:09 pm	

PART A - IMPAILINI INSPITAL STRUCTS WINDER IPPS 1.00			Title XVIII	Hospi tal	5/28/2019 12: PPS	09 pm
Next A - INPATIBLY HOSPITAL SERVICES UNDER IPPS 0 1.00 1.			TITLE AVIII	nospi tai	113	
DRS Amounts other than outlier payments for discharges occurring prior to October 1 (see 3,2,20,3) 27 1.01					1. 00	
DRG amounts other than outlier payments for discharges occurring on or after Dctober 1 (see 11,366,002 1.02 1.03	1 00				0	1 00
1.02 DRG amounts other than outlier payment for discharges occurring on or after October 1 (see 11,366,000 1.02		DRG amounts other than outlier payments for discharges occurring	g prior to October 1 (s	see		
1.03 DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring	g on or after October	l (see	11, 366, 002	1. 02
1.04 Oktober 1 (see instructions)	1.03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
2.00 Outlier payments for discharges. (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring	on or after	0	1. 04
2.02 2.02 2.01 companies for discharges for Model 4 BPCI (see instructions) 0.2.02 0.23 0.00 Managed Care Similar det Payaments 0.3.00 0		Outlier payments for discharges. (see instructions)				
Bed days available divided by number of days in the cost reporting period (see instructions) 253.58 4.00			ns)			
Indirect Medical Education Adjustment					-	
or before 12/31/1996, (see instructions) or before 12/31/1996 (see instructions) or before 12/31/31/31/31/31/31/31/31/31/31/31/31/31/	4. 00		ing period (see instru	ctions)	253. 58	4.00
new programs na accordance with 42 CFR 413. 79(e) 0.00 7.00 MACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see instructions 0.00		or before 12/31/1996. (see instructions)				
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(i)(i)(B)(2) if the cost report strandide sully 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). An amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA If the cost report straddles July 1, 2011, see instructions. An amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) An office of the structions of the count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 TEC count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 TEC count for residents in dental and podiatric programs. 0.00 10.00 TEC count for residents in dental and podiatric programs. 0.00 10.00		new programs in accordance with 42 CFR 413.79(e)				
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413. 75(b), 413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).						
8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 2. 0.00 8. 01	8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,				8. 00
8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 10.01 10.00 13.00 10.00 13.00 10.00 10.00 13.00 10.00	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.10		FTE count for allopathic and osteopathic programs in the curren	t year from your record	ds		
14.00	12. 00				0.00	12. 00
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 19.00 10.00 10.00 10.00 19.00 19.00 10		·				
16. 00 Adj ustment for residents in initial years of the program 0.00 16. 00 17. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17. 00 18. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 21. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adj ustment (see instructions) 0.000000 22. 00 1 IME payment adj ustment - Managed Care (see instructions) 0.000000 22. 01 1 Imdirect Medic al Education Adj ustment for the Add-on for § 422 of the MMA 0.000000 23. 00 2. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) <td>14. 00</td> <td>otherwise enter zero.</td> <td>ended on or after Sep</td> <td>tember 30, 1997,</td> <td></td> <td></td>	14. 00	otherwise enter zero.	ended on or after Sep	tember 30, 1997,		
17. 00		,				
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 IME payment adjustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 28.01 IME add-on adjustment amount (see instructions) 0.28.01 29.01 Total IME payment (sum of lines 22 and 28) 0.29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.0000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 IME payment adjustment - Managed Care (see instructions) 0.00 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 (f)(1)(iv)(C) 0.00 23.00 (f)(1)(iv)(C) 0.00 23.00 25.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 28.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME payment adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.28.00 29.01 Total IME payment - Managed Care			е			
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 22.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 0.000000 22.00 1ME payment adjustment (see instructions) 0.22.00 1ME payment adjustment - Managed Care (see instructions) 0.22.01 1 1 1 1 1 1 1 1 1						
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		, ,				
22. 01 IME payment adjustment - Managed Care (see instructions) 1 Indi rect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment 0.000000 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0.000000 30.00 Sum of lines 30 and 31 32.35 32.00 31.00 Allowable disproportionate share percentage (see instructions) 15.90 33.00	22.00	IME payment adjustment (see instructions)			0	22. 00
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 32.35 32.00 33.00 Allowable disproportionate share percentage (see instructions) 10.00 24.00 24.00 25.00 26.00 27.00 28.01 29.00 29.01 29.01 29.01 29.01 29.01 29.01 20.00 20.0	22. 01				0	22. 01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.00 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 31.00 Image of the same and the lower of line 23 or line 24 (see instructions) 32.00 Sum of lines 30 and 31 32.35 32.00	23. 00	Number of additional allopathic and osteopathic IME FTE residen		FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 1 IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 31.00 Allowable disproportionate share percentage (see instructions) 15.90 33.00	24.00				0.00	24.00
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Disproportionate Share Adjustment 0 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 6. 05 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 26. 30 31. 00 32. 00 Sum of lines 30 and 31 32. 35 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 15. 90 33. 00		If the amount on line 24 is greater than -O-, then enter the low	wer of line 23 or line	24 (see		
27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0.000000 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0.29. 00 29. 01 Disproportionate Share Adjustment 0.00 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 6.05 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 26. 30 31. 00 32. 00 Sum of lines 30 and 31 32. 35 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 15. 90 33. 00	26 00				0.00000	26 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 30.00 IME add-on adjustment amount (see instructions) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 32.00 IME add-on adjustment amount (see instructions) 32.00 Sum of lines add-on adjustment amount (see instructions) 33.00 Image add-on adjustment amount (see instructions) 34.00 Sum of lines add-on adjustment amount (see instructions) 35.00 Image add-on adjustment amount (see instructions) 36.00 Image add-on adjustment amount (see instructions) 37.00 Sum of lines add-on adjustment amount (see instructions) 38.00 Image add-on adjustment amount (see instructions) 39.00 Image add-on adjustment amount (see instructions) 30.00 Image add-on adjustment amou						
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 7						
29. 00 29. 01 Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31 31. 00 Allowable disproportionate share percentage (see instructions) 10. 29. 00 29. 00 29. 00 29. 01 29. 01 29. 00 20. 00 2		, , , , , , , , , , , , , , , , , , , ,				
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 29.01 29.01 29.01 29.01 29.01 20.00						
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 26.30 31.00 31.00 32.00 32.00 32.00 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				
31.00Percentage of Medicaid patient days (see instructions)26.3031.0032.00Sum of lines 30 and 3132.3532.0033.00Allowable disproportionate share percentage (see instructions)15.9033.00	30.00		ient days (see instruc	tions)	6. 05	30. 00
32.00 Sum of lines 30 and 31 32.35 32.00 33.00 Allowable disproportionate share percentage (see instructions) 15.90 33.00			J (´		
	32. 00	, , , , , , , , , , , , , , , , , , , ,				
34.00 Disproportionate share adjustment (see instructions) 1,756,407 34.00		, , , , , , , , , , , , , , , , , , , ,				1
	34. 00	Disproportionate share adjustment (see instructions)			1, 756, 407	34. 00

	Financial Systems IU HEALTH BLOOMINGTO ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet E Part A Date/Time Prep 5/28/2019 12:0	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment		1		
5. 00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	35. 00
5. 01	Factor 3 (see instructions)		0. 000340737	0. 000480022	35. 0
5. 02		zero on this line) (see	2, 305, 667	3, 971, 161	35. 0
5. 03	instructions) Pro rata share of the hospital uncompensated care payment amoun	at (soo instructions)	1, 724, 512	1, 000, 951	35. 0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	,	2, 725, 463		36. 00
0. 00	Additional payment for high percentage of ESRD beneficiary disc				30. 0
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding di		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	3			
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	, 684 an 685. (see	0		41.0
	instructions)				
1. 01	Total ESRD Medicare covered and paid discharges excluding MS-DR	RGs 652, 682, 683, 684	0		41. 0
_	an 685. (see instructions)				
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify	,	0.00		42.00
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,	683, 684 an 685. (see	O		43. 0
4 00	instructions) Patie of average Length of stay to one week (Line 42 divided by	Line 41 divided by 7	0.000000		44 00
4. 00	Ratio of average length of stay to one week (line 43 divided by days)	Time 41 divided by 7	0. 000000		44. 00
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
6. 00	Total additional payment (line 45 times line 44 times line 41.0	01)	0		46. 0
7. 00	Subtotal (see instructions)	,	49, 998, 691		47. 0
8. 00	Hospital specific payments (to be completed by SCH and MDH, sma	III rural hospitals	0		48. 0
	only. (see instructions)	·			
				Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)			49, 998, 691	49. 00
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 924, 042	
1.00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51.0
2. 00 3. 00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 See Thistructions).		7 505	52. 00 53. 00
4. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			7, 505 5, 250	54. 0
4. 01	Islet isolation add-on payment			0, 230	54. 0
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			ő	55. 0
6. 00	Cost of physicians' services in a teaching hospital (see intruc			ol	56. 0
7. 00	Routine service other pass through costs (from Wkst. D, Pt. III	•	rough 35).	0	57. 0
8. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	', col. 11 line 200)		85, 594	58. 0
9. 00	Total (sum of amounts on lines 49 through 58)			54, 021, 082	59. 0
0. 00	Primary payer payments			14, 236	60. 0
1.00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		54, 006, 846	
2.00	Deductibles billed to program beneficiaries			4, 631, 132	
3.00	Coinsurance billed to program beneficiaries			92, 460	
4. 00 5. 00	Allowable bad debts (see instructions)			472, 546	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	usti ons)		307, 155	65. 0
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	icti ons)		185, 441 49, 590, 409	66. 0 67. 0
6. 00		unlicable to MS_DPGs (se	a instructions)	49, 390, 409	68. 0
6. 00 7. 00	Ifredits received from manufacturers for renlaced devices for an			0	69. 0
6. 00 7. 00 8. 00	Credits received from manufacturers for replaced devices for ap		3)	Ö	70. C
6. 00 7. 00 8. 00 9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F				
6. 00			nstructions)	0	70. 5
6. 00 7. 00 8. 00 9. 00 0. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		nstructions)	-	
6. 00 7. 00 8. 00 9. 00 0. 00 0. 50	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstra		nstructi ons)	0	70. 8
6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration	ition) adjustment (see i	nstructions)	0	70. 8 70. 8
6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ition) adjustment (see i	nstructions)	0	70. 8 70. 8 70. 8
6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instru	ition) adjustment (see i	nstructions)	0 0 0	70. 8 70. 8 70. 8 70. 9
6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstra Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instruHSP bonus payment HVBP adjustment amount (see instructions)	ition) adjustment (see i	nstructions)	0 0 0 0 0	70. 5 70. 8 70. 8 70. 8 70. 9 70. 9
6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	ition) adjustment (see i	nstructions)	0 0	70. 8 70. 8 70. 9 70. 9 70. 9 70. 9
6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 91 0. 92 0. 93 0. 94	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ition) adjustment (see i	nstructions)	0 0 0 0 0 0 -32, 497	70. 8 70. 8 70. 8 70. 9 70. 9

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/28/2019 12:	
	Ti tl e	e XVIII	Hospi tal	PPS	
		FFY	(vvvv)	Amount	

				From 01/01/2018 To 12/31/2018	Part A Date/Time Pre	
		T' 11	\0.41 L L		5/28/2019 12:	09 pm
		IITIE	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70.04 1.000 1/01	uma adiustment for foderal ficael year (year) (Enter i	n column O		0	1. 00	70.04
	ume adjustment for federal fiscal year (yyyy) (Enter i responding federal year for the period prior to 10/1)	n corumn o		U	Ü	70. 96
	ume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 97
	responding federal year for the period ending on or af			U	Ü	10. 71
	ume Payment-3	10/1)			0	70. 98
	ustment amount (see instructions)				0	70. 99
	due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			49, 557, 912	
•	cration adjustment (see instructions)	07 & 70)			991, 158	
	ration bayment adjustment amount after sequestration				771, 130	71. 02
	n payments				48, 609, 769	
1	ve settlement (for contractor use only)				0	73. 00
1	e due provider/program (line 71 minus lines 71.01, 71.0	2 72 and			-43, 015	
73)	rade provider, program (1116); minde 11165 ; 1161, 717	27 727 0110			10, 010	/ 00
, ,	ed amounts (nonallowable cost report items) in accorda	nce with			733, 611	75. 00
	o. 15-2, chapter 1, §115.2					
	OMPLETED BY CONTRACTOR (lines 90 through 96)		•			
	ng outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
pl us 2.	04 (see instructions)					
91.00 Capi tal	outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operati	ng outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
93. 00 Capi tal	outlier reconciliation adjustment amount (see instruc	tions)			0	93. 00
94.00 The rat	te used to calculate the time value of money (see instr	uctions)			0.00	94. 00
95.00 Time va	alue of money for operating expenses (see instructions)				0	95. 00
96.00 Time va	alue of money for capital related expenses (see instruc	tions)			0	96. 00
				Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	us Payment Amount					
	nus amount (see instructions)			0	0	100. 00
	justment for HSP Bonus Payment					
	djustment factor (see instructions)	_		0.0000000000	0. 0000000000	ł
	djustment amount for HSP bonus payment (see instruction	s)		0	0	102. 00
	ustment for HSP Bonus Payment					
,	ustment factor (see instructions)			0.0000	0.0000	1
	ustment amount for HSP bonus payment (see instructions			0	0	104. 00
	community Hospital Demonstration Project (§410A Demonst					
	the first year of the current 5-year demonstration pe	riod under t	the 21st			200. 00
	/ Cures Act? Enter "Y" for yes or "N" for no.					
	imbursement	2 40)				201 00
	re inpatient service costs (from Wkst. D-1, Pt. II, lin re discharges (see instructions)	e 49)				201. 00 202. 00
1	x adjustment factor (see instructions)					202. 00
	tion of Demonstration Target Amount Limitation (N/A in	first year	of the currer	nt 5-year demonst		203.00
peri od)		iiist year	or the curren	it 5-year demonst	1 4 11 011	
	re target amount					204. 00
205 00 Case-mi	x adjusted target amount (line 203 times line 204)					205. 00
	re inpatient routine cost cap (line 202 times line 205)					206. 00
	ent to Medicare Part A Inpatient Reimbursement					200.00
	reimbursement under the §410A Demonstration (see inst	ructions)				207. 00
	re Part A inpatient service costs (from Wkst. E, Pt. A,					208. 00
						209. 00
209.00 Adjustm	ment to Medicare IPPS payments (see instructions)					1207.00
1 -						1
210.00 Reserve	ed for future use					210. 00
210.00 Reserve 211.00 Total a						1
210.00 Reserve 211.00 Total a Compari	ed for future use adjustment to Medicare IPPS payments (see instructions)	ŕ				210. 00
210.00 Reserve 211.00 Total a Compari 212.00 Total a	ed for future use adjustment to Medicare IPPS payments (see instructions) sion of PPS versus Cost Reimbursement	ŕ				210. 00 211. 00
210.00 Reserve 211.00 Total a Compari 212.00 Total a 213.00 Low-vol	ed for future use adjustment to Medicare IPPS payments (see instructions) sion of PPS versus Cost Reimbursement adjustment to Medicare Part A IPPS payments (from line	211)	nbursement)			210. 00 211. 00 212. 00
210. 00 Reserve 211. 00 Total a Compari 212. 00 Total a 213. 00 Low-vol 218. 00 Net Med	ed for future use adjustment to Medicare IPPS payments (see instructions) sion of PPS versus Cost Reimbursement adjustment to Medicare Part A IPPS payments (from line ume adjustment (see instructions)	211)	mbursement)			210. 00 211. 00 212. 00 213. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0051

					10		5/28/2019 12:	
		W/C E D+ A	A	_	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	32, 820, 327	O	32, 820, 327		32, 820, 327	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	11, 366, 002	0		11, 366, 002	11, 366, 002	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	O	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	1, 330, 492	0	968, 292	362, 200	1, 330, 492	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4.00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments Indirect Medical Education Adju	ıstment						
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1590	0. 1590	0. 1590	0. 1590		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	1, 756, 407	0	1, 304, 608	451, 799	1, 756, 407	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00	2, 725, 463	0 di scharges	1, 724, 512	1, 000, 951	2, 725, 463	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	o o	0	0	0	12. 00
13.00	Subtotal (see instructions)	47. 00	49, 998, 691	0	36, 817, 739	13, 180, 952	49, 998, 691	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	O	0	O	U	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	49, 998, 691	0	36, 817, 739		49, 998, 691	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	3, 924, 042	0	, ,		3, 924, 042	
17. 00	Special add-on payments for new technologies	54.00	5, 250	0	5, 250	0	5, 250	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

	TITIALICI AL SYSTEMS	1 (ILALIII BLOOMI			III LIE	u or rorm cws-,	2552-10
LOW VC	ILUME CALCULATION EXHIBIT 4			Provider CO	F	Period: From 01/01/2018 To 12/31/2018	5/28/2019 12:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	(0	0	18. 00
19.00	SUBTOTAL			0	35, 821, 445	18, 106, 538	53, 927, 983	19. 00
		W/S L, line	(Amounts from L)					
		0	1. 00	2.00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	3, 597, 413	0	-924, 784	4, 522, 197	3, 597, 413	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	83, 084	0	-14, 152	97, 236	83, 084	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0677	0. 0677	0. 0677	0.0677		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	243, 545	0	-62, 608	306, 153	243, 545	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 924, 042	0	-1, 001, 544	4, 925, 586	3, 924, 042	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0.000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96			()	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0051

Peri od:

From 01/01/2018

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 12/31/2018 5/28/2019 12:09 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 32, 820, 327 32, 820, 327 1.01 1.01 32, 820, 327 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 11, 366, 002 11, 366, 002 11, 366, 002 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 C for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 1, 330, 492 968, 292 362, 200 1, 330, 492 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 2.01 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0. 1590 0. 1590 0.1590 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1, 756, 407 1, 304, 608 451, 799 1, 756, 407 11.00 instructions) 1, 724, 512 11.01 Uncompensated care payments 36.00 2, 725, 463 1,000,951 2, 725, 463 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see O 0 12 00 46 00 instructions) 13.00 Subtotal (see instructions) 47.00 49, 998, 691 36, 817, 739 13, 180, 952 49, 998, 691 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 49, 998, 691 36, 817, 739 13, 180, 952 49, 998, 691 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 3, 924, 042 -1, 001, 544 4, 925, 586 3, 924, 042 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 5, 250 5, 250 5, 250 17.00 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 amount (see instructions) 19.00 SUBTOTAL 35, 821, 445 18, 106, 538 53, 927, 983 19. 00

Heal th	Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Li€	eu of Form CMS-:	2552-10
HOSPI 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2018 To 12/31/2018		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	3, 597, 413	-924, 78	4, 522, 197	3, 597, 413	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	83, 084	-14, 15	97, 236	83, 084	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see	5.00	0. 0000	0.000	0. 0000		22. 00
23. 00	<pre>instructions) Indirect medical education adjustment (see instructions)</pre>	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0677	0. 067	0. 0677		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	243, 545	-62, 60	306, 153	243, 545	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	3, 924, 042	-1, 001, 54	4, 925, 586	3, 924, 042	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4.00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-32, 497	-3, 99	-28, 502	-32, 497	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	0			0	31. 00
31. 00	HRR adjustment for HSP bonus payment (see	70. 91				0	
	instructions)	70. 71	0		0		31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	ms IU HEALTH BLOOMINGTON HOSPITAL		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051		Worksheet E Part B Date/Time Prepared: 5/28/2019 12:09 pm

			12,01,2010	5/28/2019 12:	09 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			31, 979	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		35, 658, 425	2.00
3.00	OPPS payments			35, 568, 279	3.00
4.00	Outlier payment (see instructions)			209, 399	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		110, 512	9.00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			31, 979	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
	Reasonabl e charges				
12.00	Ancillary service charges			161, 168	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	,		161, 168	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e		3		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	17.00
18. 00	Total customary charges (see instructions)			161, 168	
19. 00	Excess of customary charges over reasonable cost (complete onl	v if line 18 exceeds li	ne 11) (see	129, 189	
	instructions)	,	, (,	
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)		, ,		
21.00	Lesser of cost or charges (see instructions)			31, 979	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			35, 888, 190	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		183	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr	uctions)	6, 250, 447	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			29, 669, 539	
	instructions)		- ,		
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			29, 669, 539	30.00
31.00	Pri mary payer payments			2, 221	31.00
32.00	Subtotal (line 30 minus line 31)			29, 667, 318	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			1, 004, 567	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			652, 969	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		776, 326	36.00
37.00	Subtotal (see instructions)			30, 320, 287	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			-246	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	2, 960	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			30, 320, 533	40.00
40. 01	Sequestration adjustment (see instructions)			606, 411	40.01
40. 02	Demonstration payment adjustment amount after sequestration			0	40.02
41.00	Interim payments			29, 480, 269	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			233, 853	43.00
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	11, 039	
	§115. 2		·		
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93. 00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2018	Worksheet E
	Component CCN: 15-T051		
	Title XVIII	Subprovi der -	PPS

PART B - VEDICAL AND OTHER HEALTH SERVICES 1.00			Title XVIII	Subprovi der – I RF	PPS	
Next B - MEDICAL AND OTHER REALTH SERVICES 30 1.00 2.00				I NI	1 00	
Modical and other services (see Instructions) 39 1.00 0.0		PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
00PS payments	1.00				39	1. 00
0.00 1.00			ti ons)			
0		, ,			-	
Early Tith Poops (1st specific payment to cost ratio (see instructions) 0.000 5.00					-	
2.00 Simp of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00		· · · · · · · · · · · · · · · · · · ·	ctions)		-	
1.00 Content				-		
Ancillary service other pass through costs from West. 0, Pt. IV, col. 13, line 200 9, 00						
0.00 Organ acquisition 0.00 Organ acquisition 0.00 Organ			IV col 13 line 200			
COMPUTATION OF LESSER OF COST OR CHARGES			1 v, cor. 13, 1111e 200		-	
Reasonable charges 203 12 00 201 12 00 203 12 00 203 13 00 203 13 00 1	11. 00				39	11. 00
20.00 Ancillary service charges 203 12.00 Cost acqualstito charges (from West. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00 Cost acqualstito charges (sum of lines 12 and 13) 203 14.00 203						
3.00 Organ acquisition charges (from Wisst, D-4, Pt. III. col. 4, line 69) 0 13.00 Constonary charges (sum of lines 12 and 13) 14.00 Constonary charges (sum of lines 12 and 13) 15.00 Agreegate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 17.00 18.00 10.00 20.00	12 00				203	12 00
14.00 Total reasonable charges (sum of Fines 12 and 13) 15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0 15.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 16.00 Aggregate amount actually collected from patients Hable for payment for services on a chargebasis 0 10.00 Aggregate amount actually collected from patients 0 10.00 Aggregate amount 0 10.00 Aggregate 0 10.00			ne 69)			
15.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 16.00 And such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 16.0	14. 00		,		203	14. 00
16.00 Andounts that would have been realized from patients liable for payment for services on a chargebasis had had been made in accordance with 42 CFR 9413.13(e) 0.000000 17.00 17.00 17.00 18.10 of line 15 to line 16 (not to exceed 1.000000) 23.18.00 18.00 18.10 to file 15 to line 16 (not to exceed 1.000000) 23.18.00 25.00	45.00	3 9		 		45.00
had such payment been made in accordance with 42 CPR §413.13(e)					-	
18. 00 Total customary charges (see Instructions) 203 18. 00	10.00			ir a chargebasi s	O	10.00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 164 19. 00 165 1						
instructions		,	: 6 1: 10	11) /		
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00	19.00	, , ,	y if line 18 exceeds iii	ne II) (See	164	19.00
21.00 Lesser of cost or charges (see instructions) 0 22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 22.00 24.00 25.00 24.00 25.00	20.00	1	y if line 11 exceeds li	ne 18) (see	0	20. 00
22 00 Interns and residents (see instructions) 0 22 00 23 00 23 00 23 00 25 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 0 24, 00 24 00 25 00		1				
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 24. 00 COMPUTATION OF REINBURSENENT SETTLEMENT						
24.00 Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 24.00 COMPUTATION OF REINBURSEMENT SETTLEMENT STILEMENT STILEMENT STILEMENT SETTLEMENT STILEMENT STI		1	ructions)		-	
25.00 Deductible sand coin surance amounts (For CAH, see instructions) 0 25.00					-	
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 26.00 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 27.00 Instructions 39 30.00 Instructions 30 30.00	05 00					
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1	•	uctions)	-	
Instructions		· ·			-	
29.00 ESRD difrect medical education costs (From Wkst. E-4, line 36) 29.00 Subtotal (sum of lines 27 through 29) 39 30.00 31.00				, , , , , , , , , , , , , , , , , , , ,		
30.00 Subtotal (sum of lines 27 through 29) 39 30.00 Primary payer payments 0 31.00 Primary payer payments 0 31.00 Subtotal (line 30 minus line 31) 39 32.00 Subtotal (see instructions) 0 34.00 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 37.00 Subtotal (see instructions) 39 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 There ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 87.00 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 89.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 40.00 4			ne 50)		-	
31.00 Primary payer payments 32.00 Subtotal (line 30) minus line 31) 39.30 31.00 32.00 Composite rate ESRD (From Wkst. I - 5, line 11) 0.33.00 33.00 34.00 Allowable bad debts (see instructions) 0.35.00 35.00 Allowable bad debts (see instructions) 0.35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0.36.00 37.00 38.00 38.00 39					-	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESR0 (from Wkst. 1-5, line 11) 0 34.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 39 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.50 91.00 91.00 93.50 91.00 93.50 91.00 93.50 91.00 93.50 91.00 93.50 93.90 93		,				
33. 00 Composite rate ESRD (from Wkst. I - 5, line 11)	32. 00	Subtotal (line 30 minus line 31)			39	32. 00
34.00	22.00		CES)		0	22.00
35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.90 39.90 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 39 40.00 40.01 Sequestration adjustment (see instructions) 1 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 41.00 Interim payments 42 41.00 42.00 Tentative settlement (for contractors use only) 42 43.00 43.00 Bal ance due provider/program (see instructions) 44.00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 99.00 91.00 Outlier reconciliation adjustment amount (see instructions) 99.00 92.00 71 me Value of Money (see instructions) 99.00 93.00 00.00					-	
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 01 Interim payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1515.2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Og 93. 00 93. 00 93. 00 94. 00 Pi interior value of Money (see instructions) 99. 00 Pi interior value of Money (see instructions) 90. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 93. 00						
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39. 97 Demonstration payment adjustment amount before sequestration 0 39.97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40. 01 Subtotal (see instructions) 39.40.00 40. 01 Demonstration payment adjustment (see instructions) 1 40.01 40. 02 Demonstration payment adjustment amount after sequestration 0 40.02 41. 00 Interim payments 42 41.00 42. 00 Interim payments 42 41.00 43. 00 Bal ance due provider/program (see instructions) -4 43.00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 44.00 70. 00 Diginal outlier amount (see instructions) 0 90.00 91. 00 The rate used to		· ·	ructions)		-	
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39.50 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.01 Demonstration payment adjustment amount after sequestration 40.02 Demonstration adjustment (see instructions) 41.00 Demonstration payment adjustment amount after sequestration 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044.00 Fig. 13.00 Demonstration adjustment amount (see instructions) 44.00 Demonstration payments 42.00 Demonstration payments 43.00 Demonstration payment (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044.00 Si15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 93.00						
39. 97 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 40. 01 Sequestration payment adjustment amount before sequestration 40. 02 Demonstration payment (see instructions) 40. 02 Interim payments 41. 00 Interim payments 42. 00 Fortative settlement (for contractors use only) 43. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 91. 00 Q1. 01 Q2. 00 The rate used to calculate the Time Value of Money Q2. 00 Time Value of Money (see instructions) Q39. 97 Q39. 98 RECOVERY OF ACCELERATED DEPRECIATION Q39. 98 Q40. 00 Q40. 01 Q40. 02 Q40. 02 Q40. 01 Q40. 02 Q41. 00 Q41. 00 Q42. 00 Q42. 00 Q43. 00 Q44.		1	5)		O .	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 39. 40. 00 40. 01 Sequestration adjustment (see instructions) 1 40. 01 40. 02 41. 00 Interim payment adjustment amount after sequestration 0 40. 02 41. 00 42. 00 42. 00 43. 00 Balance due provider/program (see instructions) -4 43. 00 44. 00 44. 00 45. 00		Demonstration payment adjustment amount before sequestration			-	
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Value of Money (see instructions) 94.00 Og 93.00		•	ced devices (see instruc	tions)		
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{5115.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.00 94.00 95.00 Og 95.00 96.00 Og 97.00 97.00 Og 97.00					-	
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.00 95.00 Og 42.00 96.00 Og 97.00 97.00 Og 97.00						
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)		Demonstration payment adjustment amount after sequestration				
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 74.00 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions) 98.00 Original outlier amount (see instructions) 99.00 Original outlier amount (see instructions)		1 3				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Uniting reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	chapter 1,		
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00		§115. 2				
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	00.00					00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		1				
94.00 Total (sum of lines 91 and 93) 0 94.00					-	
	94.00	Iotal (sum of lines 91 and 93)			0	94.00

Health Financial Systems IU HEAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0051

					5/28/2019 12:0	09 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		48, 609, 76	9	29, 480, 269	1. 00
2.00	Interim payments payable on individual bills, either			o	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		48, 609, 76	9	29, 480, 269	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 01	TENTATIVE TO PROVIDER			o		5. 01
5. 02				o		5. 02
5.05	Provider to Program			<u> </u>	0	5. 05
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51	TENTITIE TO TROOM III			o	l ol	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	ا	5. 99
0. ,,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					2. 20
6. 01	SETTLEMENT TO PROVIDER			О	233, 853	6. 01
6. 02	SETTLEMENT TO PROGRAM		43, 01	5	0	6. 02
7. 00	Total Medicare program liability (see instructions)		48, 566, 75		29, 714, 122	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8.00	Name of Contractor					8. 00
	· ·			•	•	

Component CCN: 15-T051

Title XVIII Subprovi der -

		litie	XVIII	Subprovi der - I RF	PPS	
		Innatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 158, 552		42	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Provider to Program		0		0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADJUSTINIENTS TO TROUBLAND					3. 51
3. 52			Ö		Ö	3. 52
3. 53			Ö		l ol	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 158, 552		42	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
F F0	Provi der to Program					F F0
5. 50 5. 51	TENTATI VE TO PROGRAM		0 0		0	5. 50 5. 51
5. 51						5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
3. 77	5. 50-5. 98)				Ĭ	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		26, 402		4	6. 02
7.00	Total Medicare program liability (see instructions)		3, 132, 150		38	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	Thams of softi dotor	1		I .	1	5. 00

Hoal +	n Financial Systems IU HEALTH BLOOMING	TON HOSDITAL	Inlio	u of Form CMS-	2552 10
	LATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0051	Peri od:	Worksheet E-1	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/28/2019 12:	
		Title XVIII	Hospi tal	PPS	U9 piii
		THE XVIII	1103pi tui	113	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				Ī
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
33 00	Palance due provider (line 9 (or line 10) minus line 20 and l	ino 21) (coo instruction	c)		22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

32.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2018	Worksheet E-3 Part III
	Component CCN: 15-T051	To 12/31/2018	Date/Time Prepared: 5/28/2019 12:09 pm
	Title XVIII	Subprovider -	PPS

		TI LIE AVIII	I RF	PPS	
				1 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1. 00	
1.00	Net Federal PPS Payment (see instructions)			2, 805, 867	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0155	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			93, 435	3. 00
4.00	Outlier Payments			304, 863	4. 00
5.00	Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions)	ost reporting period en	nding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE coun- program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instructions)	the new program growth p	period of a "new	0. 00	7. 00
8.00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p	period of a "new	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)	,		7. 764384	10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000	11. 00
12.00	Teaching Adjustment (see instructions)			0	12. 00
13.00	Total PPS Payment (see instructions)			3, 204, 165	13. 00
14.00	Nursing and Allied Health Managed Care payments (see instruction	on)		0	14. 00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16.00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	16. 00
17.00	Subtotal (see instructions)			3, 204, 165	17. 00
18.00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			3, 204, 165	
20. 00	Deducti bl es			12, 060	
21. 00	Subtotal (line 19 minus line 20)			3, 192, 105	
22. 00	Coi nsurance			0	22. 00
23. 00	Subtotal (line 21 minus line 22)			3, 192, 105	
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		2, 600	
25. 00	Adjusted reimbursable bad debts (see instructions)			1, 690	
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 340	
27. 00	Subtotal (sum of lines 23 and 25)			3, 193, 795	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			2, 276	
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31.50
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32.00	Total amount payable to the provider (see instructions)			3, 196, 071	32.00
32. 01	Sequestration adjustment (see instructions)			63, 921	
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			3, 158, 552	
34.00	Tentative settlement (for contractor use only)	2 22 1 24		0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02			-26, 402	
36. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	cnapter I,	11, 785	36. 00
	TO BE COMPLETED BY CONTRACTOR		1		
	Original outlier amount from Wkst. E-3, Pt. III, line 4			304, 863	
51.00	,			0	51.00
	The rate used to calculate the Time Value of Money			0. 00	
53.00	Time Value of Money (see instructions)		ļ	0	53. 00

Health Financial Systems IU HEALTH BLO
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 15-0051

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 12: 09 pm

					5/28/2019 12:	09 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	2 00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	289, 181, 624) 0	0	1.00
2. 00	Temporary investments	207, 101, 024			0	1
3.00	Notes recei vabl e			, 	0	
4. 00	Accounts receivable	58, 153, 882	1		0	
5. 00	Other recei vable	9, 743, 352			0	
6. 00	Allowances for uncollectible notes and accounts receivable	7, 743, 332			0	
7. 00	Inventory	5, 515, 391	1		0	
8. 00	Prepai d expenses	3, 936, 442			0	1
9. 00	Other current assets	3, 730, 442			0	
10.00	Due from other funds				0	
11. 00	Total current assets (sum of lines 1-10)	366, 530, 691	1	<u> </u>	0	1
11.00	FIXED ASSETS	300, 330, 071		<u>, </u>	0	11.00
12. 00	Land	19, 741, 447	' .	0	0	12. 00
13. 00	Land improvements	2, 058, 207	1	_	0	1
14. 00	Accumulated depreciation	-1, 904, 393	1		0	1
15. 00	Buildings	162, 061, 316	1		0	
16. 00	Accumul ated depreciation	-136, 107, 857	1		0	1
17. 00	Leasehold improvements	1 -130, 107, 037			0	
18. 00	Accumulated depreciation	-5, 709, 555			0	1
19. 00	Fixed equipment	-5, 709, 555			0	
20. 00	Accumulated depreciation				0	1
21. 00	Automobiles and trucks	2 204 012	1		0	1
		3, 286, 012 -2, 633, 014			0	
22. 00 23. 00	Accumulated depreciation	135, 484, 527	•		0	1
24. 00	Major movable equipment Accumulated depreciation		1		0	
25. 00		-110, 877, 981			0	
	Minor equipment depreciable				0	1
26. 00	Accumulated depreciation				0	
27. 00 28. 00	HIT designated Assets				0	1
	Accumulated depreciation					
29. 00	Mi nor equi pment-nondepreci abl e	VE 200 700			0	1
30. 00	Total fixed assets (sum of lines 12-29)	65, 398, 709	<u> </u>) 0	0	30.00
31. 00	OTHER ASSETS Investments	14 242 010) C) 0	0	31.00
31.00		14, 362, 919			0	
	Deposits on leases					1
33. 00	Due from owners/officers	202 072 4/0			0	1
34. 00	Other assets	202, 872, 460			0	
35. 00	Total other assets (sum of lines 31-34)	217, 235, 379	1		0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	649, 164, 779	<u> </u>	0	0	36. 00
27 00	CURRENT LIABILITIES	17 010 227) 0	0	27 00
37. 00	Accounts payable	17, 912, 337	1		0	
38. 00	Salaries, wages, and fees payable	11, 199, 381		0	0	1
39. 00	Payroll taxes payable	1 770 000			0	
40. 00	Notes and Loans payable (short term)	1, 770, 000			0	1
41. 00	Deferred income	0		0	0	
42.00	Accel erated payments	0)			42.00
43. 00	Due to other funds	0 740 ((0		0	0	1
44. 00	Other current liabilities	2, 718, 663	1		0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	33, 600, 381) 0	0	45. 00
47.00	LONG TERM LIABILITIES	1 ~		\		4, 00
46. 00	Mortgage payable	0		0	0	1
47. 00	Notes payable	0			0	1
48. 00	Unsecured Loans	0 00 00 017) C	-	0	1
49. 00	Other long term liabilities	25, 996, 947			0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	25, 996, 947		_	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	59, 597, 328	S C	0	0	51.00
	CAPI TAL ACCOUNTS					1
52. 00	General fund balance	589, 567, 451				52. 00
53. 00	Specific purpose fund		0)		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					1
59. 00	Total fund balances (sum of lines 52 thru 58)	589, 567, 451	1	-	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and	649, 164, 779	r) c	0	0	60.00
	[59]	I	I			I

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0051

Period: Worksheet G-1 From 01/01/2018

17.00

18.00

19.00

0

0

12/31/2018 Date/Time Prepared: 5/28/2019 12:09 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 509, 358, 912 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 110, 520, 543 2.00 Total (sum of line 1 and line 2) 3.00 619, 879, 455 0 3.00 4.00 PENSION OBLIGATION 23, 630, 119 0 0 4.00 5.00 DONATED PP&E 22, 359 0 5.00 6.00 6.00 0 0 7.00 0 7.00 0 8.00 8.00 0 0 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 23, 652, 478 0 10.00 Subtotal (line 3 plus line 10) 643, 531, 933 11.00 11.00 0 UNRESTRICTED FUND BALANCE 12.00 53, 964, 481 0 0 12.00 13.00 ROUNDI NG 13.00 14.00 0 0 14.00 0 0 15.00 15.00 0 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 53, 964, 482 18.00 Fund balance at end of period per balance 589, 567, 451 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 PENSION OBLIGATION 4.00 4.00 5.00 DONATED PP&E 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 UNRESTRICTED FUND BALANCE 0 12.00 13.00 ROUNDI NG 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00

0

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems IU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0051

			10	5 12/31/2018	5/28/2019 12:0	
	Cost Center Description		Inpati ent	Outpati ent	Total	J 7 рііі
	555 Conton 5555 FET 6.1		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				2. 22	
	General Inpatient Routine Services					
1.00	Hospi tal		128, 216, 604		128, 216, 604	1. 00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF		6, 019, 532		6, 019, 532	3.00
4.00	SUBPROVI DER		0		0	4. 00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		134, 236, 136		134, 236, 136	10. 00
	Intensive Care Type Inpatient Hospital Services		00 (0) 05(1	00 (0) 05(
11.00	INTENSIVE CARE UNIT		22, 696, 356		22, 696, 356	
12.00	CORONARY CARE UNIT		17, 404, 329		17, 404, 329	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT		17 015 510		17 015 510	14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT		17, 315, 512		17, 315, 512	
16. 00	Total intensive care type inpatient hospital services (sum of	rines	57, 416, 197		57, 416, 197	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		191, 652, 333		191, 652, 333	17. 00
18. 00	Ancillary services		439, 399, 032	629, 529, 917		17. 00
19. 00	Outpatient services		49, 604, 489	210, 786, 009	260, 390, 498	
20. 00	RURAL HEALTH CLINIC		47, 004, 407	210, 780, 007	200, 370, 470	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		O	0	0	22. 00
23. 00	AMBULANCE SERVI CES		244, 421	45, 408, 636	45, 653, 057	23. 00
24. 00	CMHC		211, 121	107 1007 000	10, 000, 007	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25. 00
26. 00	HOSPI CE		0	0	0	26. 00
27. 00	OTHER NRCC		0	7, 945, 969	7, 945, 969	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	680, 900, 275		1, 574, 570, 806	
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			337, 104, 544		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0	_		35. 00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38.00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41. 00 42. 00	Total deductions (sum of lines 37-41)		U			41. 00 42. 00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		337, 104, 544		42.00
45.00	to Wkst. G-3, line 4)	/ (transier		337, 104, 344		45.00
	100 mot. 5 0, 11110 4/	1		l		

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0051	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared·
			10 12/01/2010	5/28/2019 12:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			1, 574, 570, 806	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		1, 139, 716, 627	2. 00
3.00	Net patient revenues (line 1 minus line 2)			434, 854, 179	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		337, 104, 544	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			97, 749, 635	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients	·		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
	MI SCELLANEOUS I NCOME			12, 770, 908	
	Total other income (sum of lines 6-24)			12, 770, 908	
	Total (line 5 plus line 25)			110, 520, 543	
	OTHER EXPENSES (SPECIEV)			0	1

0 27.00

110, 520, 543 29. 00

28. 00

27. 00 OTHER EXPENSES (SPECIFY)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

CALCUL	LATION OF CAPITAL PAYMENT	Provider CCN: 15-0051	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/28/2019 12:0 PPS	09 pm
	DADT I FILLY PROCRECTIVE METURE			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			3, 597, 413	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			3, 377, 413	
2. 00	Capital DRG outlier payments			83, 084	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			03, 004	2.0
3. 00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructions)	153. 34	
1. 00	Number of interns & residents (see instructions)	reporting period (see ins	ti do ti ono)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
. 00	Indirect medical education adjustment (multiply line 5 by 1.01)(see instructions)	the sum of lines 1 and 1.0	1, columns 1 and	0	
. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet	E, part A line	6. 05	7. 0
. 00	Percentage of Medicaid patient days to total days (see ins	tructions)		26. 30	8. 0
. 00	Sum of lines 7 and 8			32. 35	
0. 00	Allowable disproportionate share percentage (see instructi	ons)		6. 77	
1.00	Disproportionate share adjustment (see instructions)			243, 545	
2. 00	Total prospective capital payments (see instructions)			3, 924, 042	12. 0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 0
2. 00	Program inpatient ancillary capital cost (see instructions)		0	2. 0
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 0
1. 00	Capital cost payment factor (see instructions)			0	•
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.0
2. 00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	2. 0
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3.0
. 00	Applicable exception percentage (see instructions)			0.00	
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 0
. 00	Percentage adjustment for extraordinary circumstances (see			0. 00	
. 00	Adjustment to capital minimum payment level for extraordin	ary circumstances (line 2 :	x line 6)	0	7.0
. 00	Capital minimum payment level (line 5 plus line 7)			0	
. 00	Current year capital payments (from Part I, line 12, as ap		l 1: - 0)	0	9.0
9. 00 10. 00 11. 00	Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove	o capital payments (line 8		0	9. 0 10. 0 11. 0

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00

0 17.00

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

13.00

14.00